Newborn Screening Benefits Program

Contractor Procedures Manual

Department of State Health Services

Newborn Screening Unit

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Table of Contents

INTRODUCTION
General Information

PURPOSE OF MANUAL

The Department of State Health Services (DSHS) Contractor Procedures Manual for the Newborn Screening (NBS) Benefits Program provides guidance for contractors who deliver services using NBS Benefits Program funds in Texas. To provide services through the NBS Benefits Program, contractors are required to be in compliance with the requirements in this manual.

PROGRAM OVERVIEW

In 2005, during the Regular Session of the 79th Legislature, House Bill 790 was passed requiring expansion of the newborn screening panel to the American College of Medical Genetics (ACMG) recommended core panel, as funds allowed. Effective December 2006, the program began screening for 27 disorders. Increasing the panel from 7 to 27 disorders led to an increase in the number of presumptive positive screens as well as a greater need for confirmatory testing, evaluation, and treatment services. In December 2009, the program added Cystic Fibrosis to the newborn screening panel thus bringing the total number disorders screened for to 28.

The legislation resulted in the adoption of Texas Administrative Code (TAC), Title 25, Chapter 37 – Maternal and Infant Health Services, Subchapter D - Newborn Screening Program (§§37.51-37.65), which details the disorders for which newborns are screened; responsibilities of providers and parents; screening procedures; the provisions of follow-up care; and the provision of services provided through program benefits for specified populations.

In order to meet increased needs for services, DSHS entered into an open enrollment process to procure the services from public and private providers. The NBS Benefits Program began operating in March 2007. The program offers reimbursement to enrolled providers for the provision of specified services to eligible clients at Medicaid rates for clinical services. Enrolled laboratories and providers of remediation services are reimbursed at established rates (See Section III). The program provides services to eligible clients in accordance with 25 TAC §§37.51-37.65.

The NBS Benefits Program is comprised of four categories of service providers:

1. medical providers
2. laboratories
3. pharmacies
4. providers of low-protein diet foods

The services to be provided are:

1. clinical evaluations and follow-up care
2. confirmatory laboratory testing
3. medications
4. vitamins

5. dietary supplements

This program does not cover DME's (e.g. syringes, needles, and test strips).

Depending on available funding, program benefits will be provided to the following priority populations, who meet all the eligibility criteria listed in this section, in the following order:

1. Children 0-2 years of age
2. Children 3-5 years of age
3. Children 6-21 years of age
4. Pregnant women
5. Women of child bearing age
6. Adults (female or male)

PROCESS DESCRIPTION

NBS Benefits Program contractors shall provide or assure the provision of benefits to include confirmatory testing, follow-up care, and remediation services for eligible clients. Confirmatory testing is indicated when an individual has a positive presumptive screen of a disorder screened by the NBS Program. Components include patient evaluation, one or more supplemental laboratory tests to substantiate or refute results of the screen, and if confirmed, management of the disorder. Remediation services include those dietary supplements, vitamins, and medications prescribed by the provider and deemed necessary for the treatment and management of the diagnosed disorder.

Texas newborns are mandated to receive two newborn screens. The first screen is completed within 24 to 48 hours after birth. The second screen is obtained within one to two weeks of age. Blood specimens from infants are analyzed by the DSHS Laboratory in Austin. Abnormal results are reported by the Laboratory staff to the NBS Clinical Care Coordination staff. Clinical Care staff provide follow-up to assist in linking families to health care providers who can confirm test results and ensure appropriate treatment.

Initial notification of abnormal results is made to the primary care provider (PCP) who may refer cases to a specialist, or consultant.

As specified in this manual, the NBS Benefits Program will reimburse public and private providers, who are enrolled as NBS Benefits contractors, providing services to eligible clients at the established rates. To utilize NBS Benefits program services, the PCP, Specialist, or other health care practitioner must refer potential clients to medical providers who are enrolled in the program as contractors. Within the limits of available funding, the NBS Benefits Program will provide confirmatory testing and follow-up care at no cost or reduced cost to individuals approved for benefits who have a disorder detected through the screening program. Once confirmed with appropriate diagnostic tests that have been interpreted by a physician recognized by the department as a specialist in metabolic diseases, the contracted medical provider may prescribe dietary supplements, medications, and vitamins.

The patient will be responsible for obtaining the prescribed treatment from the enrolled pharmacy or provider of low-protein diet foods. The PCP, specialist, or other health care provider's office will serve as the intermediary for the client's services including providing follow-up to ensure client services have been provided.

MEDICAL PROVIDERS QUALIFICATIONS

The NBS Benefits Program is committed to assisting families in need of these services, and therefore has entered into open-enrollment contracts with Texas providers. To qualify for enrollment in the NBS Benefits Program, medical providers must be currently enrolled as a Medicaid Provider in Texas and:

- Board Certified/Board Eligible physicians (may also be an active candidate of the American Board of Medical Geneticist) in Medical Biochemical Genetics, or Clinical Biochemical Genetics. Medical Geneticists who are physicians and boarded in Clinical Genetics are eligible, but must be able to document having been active in the management of patients with inborn errors of metabolism at least 25% of their time in the two years prior to submitting an application;

- Board Certified/Board Eligible Adult and Pediatric Endocrinologists (Adult-Endocrinology, Diabetes, and Metabolism), or Pediatric Endocrinology;

- Board Certified/Board Eligible Adult and Pediatric Hematologists (Adult-Hematology) or Pediatric Hematology (Hematology/Oncology); or

- Board Certified/Board Eligible Adult and Pediatric Pulmonologists;

LABORATORY PROVIDER QUALIFICATIONS

To qualify for enrollment in the NBS Benefits Program, *laboratories* shall:

- Be CLIA certified and must provide a copy of their CLIA certification attached to the application;

- Have the capacity to conduct confirmatory testing and follow-up testing for individuals identified through the Texas Newborn Screening Program as being at risk for a hereditary metabolic, endocrine, or hematologic disorder.

PHARMACY PROVIDER QUALIFICATIONS

To qualify for enrollment in the NBS Benefits Program, *pharmacies* shall:

- Ensure that they can provide medications, vitamins and dietary supplements prescribed by health care provider specializing in metabolic, endocrine, or hematologic disorders;

- Be a Class A (may include compounding pharmacies), a Class C (institutional pharmacy), a Class D (clinical pharmacy), or Class E (mail-order) pharmacy. Evidence of licensure must be provided with the enrollment application.

LOW-PROTEIN DIET FOOD PROVIDERS QUALIFICATIONS

To qualify for enrollment in the NBS Benefits Program, providers of low-protein diet foods may be manufacturers or retailers of low-protein diet foods. Both manufacturers and retailers must supply their tax ID number and their license/permit number (if appropriate).

DEFINITIONS

Below are some general definitions of terms or phrases that are used throughout this manual.

Age – For a child to be counted as part of the household, the child must be under 18 years of age and unmarried. The eligibility worker should terminate the child's eligibility at the end of the month the child becomes 18 unless the child is:

- A full-time student (as defined by the school) in high school, attends an accredited GED class, or regularly attends vocational or technical training as an equivalent to high school attendance, and

- Expected to graduate before or during the month of his/her 19th birthday.

If the child does not meet the above criteria, he/she will be considered a separate household of one.

Children Health Insurance Program (CHIP) – A child health insurance program for non-Medicaid eligible children with a family income up to 200% FPL.

CHIP Perinatal Program – HHSC program that provides medical coverage for perinatal care of unborn children of non-Medicaid eligible women with an income up to 200% FPL.

Child and Adolescent – A person from his/her 1st birthday through the 21st year.

Contractor – Any entity DSHS has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually implements the services.

Consultation – A type of service provided by a physician with expertise in a medical or surgical specialty and, who upon request of another appropriate healthcare provider, assists with the evaluation and/or management of a patient.

Department of State Health Services (DSHS) – The agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.

Diagnosis – The recognition of disease status determined by evaluating the history of the patient and the disease process, and the signs and symptoms present. Determining the diagnosis may require microscopic (i.e. culture), chemical (i.e. blood tests), and /or radiological examinations (i.e. x-rays).

Documented Immigrant – A person who is not a United States (U.S.) citizen, and has an immigration document.

Documentation – Process of recording eligibility and/or health information provided by the applicant.

Eligibility Date – An individual is entitled to services beginning with the date the completed application was submitted, provided it is approved. The eligibility expiration date will be twelve months from the eligibility date.

Family Composition – A person living alone or a group of two or more persons related by birth, marriage (including common law), or adoption, who reside together and who are legally responsible for the support of the other person.

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. In the U. S., this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

Health and Human Services Commission (HHSC) – State agency that has oversight responsibilities for designated health and human services agencies, including DSHS, and administers certain health and human services programs including the Texas Medicaid Program, Children's Health Insurance Program (CHIP), and Medicaid waste, fraud, and abuse investigations.

Health Service Region (HSR) – For administrative purposes, DSHS has grouped counties within a specified geographic area into 11 Health Service Regions.

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options and the benefits and risk of taking no action are explained to a patient in a manner that is understandable to that patient and allows her/him to participate and make sound decisions regarding her/his own medical care.

Immediate Medical Need – Documented statement from a physician stating that the services are urgent and medically necessary for Medicaid, CHIP, or private insurance determination.

Laboratory, X-Ray, or other Appropriate Diagnostic Services – Studies or tests ordered by the patient's health care practitioner(s) to evaluate an individual's health status for diagnostic purposes.

Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Minor – A person who has not reached his/her 18th birthday and who has not had the classification of minor removed in court or who is not or never has been married or recognized as an adult by the State of Texas.

Nutritional Services – Services that identify the nutritional status of an individual, and instruction which included appropriate dietary information based on the patient's needs, i.e. age, sex, health status, culture. This may be provided on an individual, one-to-one basis, or to a group of individuals.

Outreach – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of participants.

Prescription Drugs and Devices and Durable Supplies – Medically-necessary pharmaceuticals, medical supplies (capable of withstanding wear) needed for the treatment of a diagnosed condition.

Presumptive Eligibility – Short-term access to health care services up to 60 days. An immediate medical need must exist and is determined by a medical professional. The applicant must screen eligible for services.

Priority Population – Low income, uninsured or underinsured individuals enrolled in the benefits program. Dependent on funding availability, benefits will be provided in the following priority order:

1. Children 0-2 years of age
2. Children 3-5 years of age
3. Children 6-21 years of age
4. Pregnant women
5. Women of child bearing age
6. Adults (female or male)

Provider – A clinician or group of clinicians, who provide services including health care providers, physicians, dieticians, pharmacies, etc.

Renewal – The process of re-screening and determining eligibility for the next year.

Referral Agency – An agency that will provide a service for the NBS Benefits Program client that the NBS Benefits Program contractor does not provide and it is not a reimbursable NBS Benefits Program service.

Service – Any patient encounter at a facility that results in the patient having a medical or health-related need met including counseling and guidance to assist the patient and family in locating, accessing, and using appropriate community resources.

State Fiscal Year - September 1 – August 31.

Texas Resident – An individual who resides within the geographic boundaries of the state.

Treatment – Any specific procedure used for the cure or improvement of a disease or pathological condition.

Undocumented immigrant – A person who is not a U.S. citizen, and has no immigration document.

Unduplicated Client – Clients are counted only once per category regardless of the number of services they receive; client can be counted once in prenatal, dysplasia, family planning, and child health, as appropriate. One client seen four times in one category is counted as one unduplicated client and a family of three seen once is counted as three unduplicated clients.

SECTION I: CLIENT SERVICES POLICIES AND PROCEDURES

CLIENT ELIGIBILITY

For an individual to receive Newborn Screening Benefits, the individual must meet all four (4) eligibility criteria must be
met:

- Have a positive presumptive screen or a confirmed diagnosis of a heritable disorder screened by the program;
- Be a Texas resident;
- Have a family income at or below 350% of the federal poverty income level (FPL); and
- Not eligible for other programs/benefits providing the same services.

An individual is not eligible to receive benefits from the program at no cost or reduced cost to the extent that the individual or the parent, managing conservator, or other person with a legal obligation to support the individual is eligible for some other benefit, such as Medicaid, Children With Special Health Care Needs (CSHCN), Children's Health Insurance Plan (CHIP) or private insurance that would pay for all or part of the services.

Contractor Responsibilities (Dieticians and Medical Providers)

The contractor must ensure that eligibility forms are complete and include documentation of the following:

- Individual/family name, present address, date of birth, and whether the individual/family members are currently eligible for Medicaid or other benefits;
- Health insurance policies, if applicable, providing coverage for the individual, spouse, and dependent(s);
- Monthly income of individual and spouse;
- Advise the individual of his/her responsibility to report changes and the types of changes the individual must report for application approval and at each annual review;
- Other benefits available to the family or individual, documentation that the applicant has applied for other benefits and proof of ineligibility;
- Any specified or other supporting documentation necessary for the NBS Benefits Program to determine eligibility; and
- Ensure that the client picks a pharmacy and/or low-protein food manufacturer.

Contractor Responsibility in Eligibility Determination (Dieticians and Medical Providers)

The provider will:

- Provide assistance if the applicant needs help in completing the NBS Benefits Program Application for Services, the Statement of Applicant's Rights and Responsibility Form, and the Presumptive Eligibility Form (if applicable);
- Assist the individual in designating additional contacts to verify their eligibility information, if requested by the individual;
- Ensure that **completed** forms are sent/faxed to NBS Benefits Program at one time;

- By following-up with the individual and the NBS Benefits Program, ensure that individuals who are given forms to complete at home, mail/fax forms to NBS Benefits Program;
- Document any reported changes and the date of the reported changes in the client's file;
- Inform NBS Benefits Program of any changes within 30 days.

Verification of information may be necessary when there is contradictory or discrepant information and/ or when information that does not sufficiently explain the circumstances to support an eligibility decision. The NBS Benefits Program shall allow the applicant an opportunity to resolve any discrepancy by providing documentary evidence or designating a suitable contact to verify information. If the applicant fails or refuses to do so, eligibility can be denied.

The contractor is also responsible for assisting the client in picking a pharmacy and a low protein food manufacturer. The client will need to stay with the same pharmacy and low protein food manufacturer for the entire 12 months of eligibility. If the client encounters issues or concern with the pharmacy or low protein food manufacturer, the contractor must work with the NBS Benefits Program staff to resolve the situation. Under some circumstances, a change may be warranted.

Applicant's Responsibility for Providing Proof

- Complete the NBS Benefits Program Application for Services or request assistance for completion;
- Applicants are responsible for providing documents requested by the contractor. Failure to document all required information will result in denial of eligibility. If documentation is not available or is insufficient to determine eligibility, contractor staff should ask the individual to designate a contact person to provide the information. Information about the individual designated to confirm the applicant's information is for contact purposes and does not need to be collected if that source is an individual listed on the application form or is present during the interview.

Client's Responsibility for Reporting Changes

A client must report changes to the Dietician or Medical Provider in the following areas: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or other third-party coverage benefits. The client may report changes by mail, telephone, in-person, or through someone acting on the client's behalf. Changes must be reported no later than 30 days after the client is aware of the change. If changes affect eligibility and are not reported within 30 days, the client is subject to denial of benefits. By signing the required forms, the client attests to the truth of the information provided.

NBS Benefits Program Responsibilities in Eligibility Determination

NBS Benefits Program will ensure the eligibility process is completed within 7 working days (2 working days for Immediate Need cases) from the date the completed

application was received and that the client record includes all appropriate eligibility documentation. NBS Benefits Program will:

- Accept NBS Benefits Program Application for Services that has been appropriately completed, recording the date on which it was received;
- Ensure that documentation provided by the applicant is sufficient to make an eligibility decision, or specify an additional source required to make that decision;
- Determine the effect the reported changes have on the client's eligibility by re-screening and revising the client's NBS Benefits Program Application for Services, or completing a new one;
- Inform applicants deemed ineligible for benefits of their right to appeal the eligibility determination to NBS Benefits Program if they believe that information was incorrectly considered;
- File completed/signed forms, denial letters and appropriate documentation in the client's record;
- Notify Dietician or Medical Provider when forms are incomplete;
- Send, email (using secured software), or fax contractors for their files:
    - A copy of the approval/denial letters for Presumptive Eligibility, NBS Benefits Program Application for Services, and subsequent updated applicant information to the contracted specialist /coordinating provider;
    - Annual Renewal is the annual eligibility review, which is prompted by the anniversary date on which the client was determined eligible for benefits.

SCREENING AND ELIGIBILITY DETERMINATION

To determine if an individual is eligible for services, the NBS Benefits program will:

- Determine if the individual meets all four (4) eligibility criteria:
    1. Have a positive presumptive screen or a confirmed diagnosis of a heritable disorder screened by the program;
    2. Be a Texas resident;
    3. Have a family income at or below 350% of the federal poverty income level (FPL); and
    4. Not eligible for other programs/benefits providing the same services.

Note: If the individual has medical coverage through private insurance or other program (Medicaid, CHIP, etc.), they are not eligible. Applicants may apply for a waiver under conditions described in detail below.

- Identify if the applicant is potentially eligible for Medicaid, CHIP, etc. by completing the NBS Benefits Program Application or the short form on HHSC website.
- Before submitting application to NBS Benefits Program, the applicant must apply for other programs (Medicaid, CHIP, etc.) if potentially eligible for the other program.

Note: This may take several weeks. For applicants with an Immediate Medical Need, see Presumptive Eligibility below.

- Once the applicant is denied other program coverage, submit the denial letter with the applicants signed NBS Benefits Program Application, required documentation and the signed Statement of Applicant's Rights and Responsibilities to the NBS Benefits Program for eligibility determination.

- Annual Renewal – This step is the annual eligibility review prompted by the anniversary date the client was deemed eligible for the NBS Benefits Program. The NBS Benefits Program Application for Services is used to determine continued eligibility and/or update eligibility status. For example, if a client was deemed eligible for the NBS Benefits Program on August 31, 2005, then the client must be re-certified for eligibility before he/she can access services after August 31, 2006. The renewal can be performed before the anniversary date the client was deemed eligible for the NBS Benefits Program or before services are provided on the first visit after the anniversary date.

Individuals must be screened for potential Medicaid, CHIP, or other programs prior to applying for the NBS Benefits Program. The contractor must document proof in the clients' medical record.

For NBS Benefits Program purposes, contractors may use the HHSC-*Your Texas Benefits* website (www.yourtexasbenefits.com) to assist in the determination of an individual's eligibility. The website offers access to information on HHSC benefits including Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Children's Health Insurance (CHIP), and nursing home care and other services for people who are elderly or have disabilities.

NBS Benefits Program Application for Services

The individual or parent is responsible for completing page one of his/her own application. If assistance is needed in completing the NBS Benefits Program Application for Services the family should contact their provider (i.e. contractor, nutritionist, nurse, medical assistant or social worker). One form must be completed for each family member being screened for eligibility. To expedite the process, it is acceptable to fill out the form once and photocopy the form for the number of family members needed. The family member name listed under the family composition chart on question 1 can be highlighted or circled to indicate the intended client record in which it shall be filed. Each individual applicant, who is a legal adult, is required to sign and date the form. If confidentiality of services is a concern, separate forms for spouses may be completed. The signature of anyone assisting in completion of the form is required as well. The form is filed in the client record.

Family Composition

Establishing family size is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of family members. A family is defined as a person living alone or a group of two or more persons related by birth, marriage (including common law), or adoption, which reside together and are legally responsible for the support of the other person. Unborn children are also included in family size.

Children and Family Composition
For a child to be counted as part of the household, the child must be under 18 years of age and unmarried. Termination of benefits occurs at the end of the month the child becomes 18 unless the child is:

- A full-time student (as defined by the school) in high school, attends an accredited GED class, or regularly attends vocational or technical training as an equivalent to high school attendance, and
- Expected to graduate before or during the month of his/her 19th birthday.

If the child does not meet the above criteria, he/she will be considered a separate household of one.

A child may be considered part of a family when living with relatives other than natural parents if documentation can be provided that verifies the relationship. Acceptable documents include birth certificates or other legal documents that demonstrate the relationship between the caretaker and the child. If the child is not biologically related to the care provider, document the relationship on the NBS Benefits Program Application for Services.

Documentation of Family Composition
To document family relationships, one of the following items shall be provided, if questionable:

- Birth certificate
- Baptismal certificate
- School records
- Other documents or proof of family relationship determined valid by the contractor to establish the dependency of the family member upon the applicant or head of household.

Family members who receive other health care benefits are included in the family count. The contractor has discretion to document special circumstances in the calculation of family composition. Additionally, if a separate family group is established within the household based on the documentation gathered, document the basis used for determining separate households on the NBS Benefits Program Application for Services.

Residency
To be eligible for NBS Benefits, an individual must be physically present within the geographic boundaries of Texas and:

- Has intent to remain within the state, whether permanently or for an indefinite period (Signing the Rights and Responsibility Form provides declaration of the intent to remain in the state);
- Not claim residency in any other state or country; and/or
- If less than 18 years of age, his/her parent, managing conservator, or guardian must be a resident of Texas.

Although the following individuals may reside in Texas, they are not considered Texas residents for the purpose of receiving NBS Benefits and are considered ineligible:

- Persons who move into the state solely for the purpose of obtaining health care services.
- Students primarily supported by their parents, whose home residence is in another state.

Individuals described below are not eligible to receive NBS Benefits:

- Inmates of correctional facilities.
- Residents of state schools.
- Patients in state psychiatric hospitals.

Documentation of Residency

Document the proof of residency provided by the applicant on the NBS Benefits Program Application for Services and explain why residency is questionable, if necessary. For documentation of residency, one of the following items shall be provided:

- Valid Texas driver license.
- Current voter registration.
- Rent or utility receipts for one month prior to the month of application.
- Motor vehicle registration.
- School records.
- Medical cards or other similar benefit cards.
- Property tax receipt.
- Mail addressed to the applicant, his/her spouse, or children if they live together.
- Other documents considered valid by the contractor.

If none of the listed items are available, residency may be verified through:

- Observance of personal effects and living arrangements.
- Statements from a landlord, neighbor, or other reliable sources.

Temporary Absences from State

Individuals do not lose their residency status because of temporary absences from the state. For example, a migrant or seasonal worker may travel during certain times of the year but maintains a home in Texas and returns to that home after these temporary absences. If a family is otherwise eligible, but residence is in question/dispute, the household is entitled to services until factual information regarding residency change proves otherwise.

Income

To be eligible for NBS Benefits Program, applicants must have a gross family income at or below 350% FPL. The table below details sources of earned and unearned income that contribute to the calculation of gross family income as well as income that is exempt from being counted.

Types of Income	Countable	Exempt
Adoption Payments		X
Cash Gifts and Contributions*	X	
Child Support Payments*	X	
Child's Earned Income		X
Crime Victim's Compensation*		X
Disability Insurance Benefits*	X	
Dividends, Interest, and Royalties*	X	
Educational Assistance		X
Energy Assistance		X
Foster Care Payment		X
In-kind Income		X
Job Training		X
Loans (Non-educational)*	X	
Lump-Sum Payments*	X	X
Military Pay*	X	
Mineral Rights*	X	
Pensions and Annuities*	X	
Reimbursements*	X	
RSDI/Social Security Payments*	X	
Self-Employment Income*	X	
SSDI	X	
SSI Payments		X
TANF		X
Unemployment Compensation*	X	
Veteran Administration*	X	X
Wages and Salaries, Commissions*	X	
Worker's Compensation*	X	

*Explanation of countable income provided below

Definitions of Countable Income

Cash Gifts and Contributions – Countable, Exemption: cash gifts and contributions made by a private, non-profit organization on the basis of need and total $300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January – March, April – June, July – September, and October – December. If these contributions exceed $300 in a quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a noncertified household member who:

- Lives in the home with the certified household member;
- Shares household expenses with the certified household member; and
- No landlord/tenant relationship exists.

Child Support Payments – Count income after deducting $75 from the total monthly child support payments the household receives.

Disability Insurance Payments/Social Security Disability Insurance (SSDI) – Countable, SSDI is a payroll tax-funded, federal insurance program of the Social Security Administration.

Dividends, Interest, and Royalties – Countable, Exception: Exempt dividends from insurance policies as income. Count royalties, minus any amount deducted for production expenses and severance taxes.

In-Kind Income – Exempt, An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Loans (Non-educational) – Count as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – Count as income in the month received if the person receives it or expects to receive it more than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay – Count all military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – Countable, A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, gravel, etc.

Pensions and Annuities – Countable, A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements – Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

Retirement, Survivors, and Disability Insurance (RSDI)/Social Security Payments Count the RSDI benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

Self-Employment Income – Count the total gross earned, minus the allowable costs of producing the self-employment income.

Supplemental Security Income (SSI) Payments – Exempt.

Terminated Employment – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. Income is terminated if it will not be received in the next usual payment cycle.

Unemployment Compensation Payments – Count the gross benefit less any amount being recouped for an overpayment.

Veterans Administration (VA) Payments – Count the gross VA payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions – Count the actual (not taxable) gross amount.

Worker's Compensation – Count the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. NOTE: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

Exclusions
The NBS Benefits Program does not examine resources such as bank accounts, vehicles or real estate ownership when determining eligibility. One-time payments, such as monies derived from the sale of real or personal property, gifts, tax refunds, and insurance payments or compensation for injury are not considered income for the purpose of NBS Benefits Program eligibility determination.

Documentation of Income
Documentation of income must be provided to complete the NBS Benefits Program Application for Services. Declarations of "unknown" will not be accepted as representations of required facts and documentation. Incomplete or inadequately documented eligibility determination will result in limitations in the provision of funded services. To document income, the following documentation shall be provided for a

minimum of four (4) consecutive current pay periods or one month's pay, only if paid same gross amount on a monthly basis, unless special circumstances are noted on the NBS Benefits Program Application for Services:

- Copy (ies) of the most recent paycheck(s).
- Copy (ies) of the most recent paycheck stub/monthly earning statement(s).
- Employer's written verification of gross monthly income or the Employment Verification Form (Form 128).
- Award letters.
- Domestic relation printouts of child support payments.
- Letter of support.
- Unemployment benefits statement or letter from the TWC.
- Award letters, court orders, or public decrees to verify support payments.
- Notes for cash contributions.
- Other documents or proof of income determined valid by the contractor.

If all attempts to document income are unsuccessful because the employer/payer fails or refuses to provide information or threatens continued employment, and no other proof can be found, staff may determine an amount to use on the form based on the best available information and document the determined income on the NBS Benefits Program Application for Services.

Income Determination Procedure

Count all income already received and any income the family expects to receive. When an individual has not received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented on the NBS Benefits Program Application for Services.

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Use at least four consecutive, current pay periods to calculate projected monthly income. If indiviual is paid one time per month and receives the same gross pay each month, then one pay period will suffice.

If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- Weekly income x 4.33
- Every two weeks x 2.17
- Twice a month x 2.0

Dependent childcare expenses shall be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to $200 per child per month for children under age 2 and $175 per child per month for children age 2 to 12 or age 2 to 18 if child is disabled.

Legally-obligated child support payments made by a member of the household group shall also be deducted. Payments made weekly, every two weeks, or twice a month must be converted to a monthly amount by using one of the above listed conversion factors.

Self-Employment Income – If an applicant earns self-employment income, it must be added to any income received from other sources.

- Annualize self-employment income that is intended for an individual or family's annual support, regardless of how frequently the income is received.
- If the self-employment income is only intended to support the individual or family for part of the year, average the income over the number of months it is intended to cover.
- If the individual has had self-employment income for the past year, use the income figures from the previous year's business records or tax forms.
- If current income is substantially different from income the previous year, use more current information, such as updated business ledgers or daybooks. Remember to deduct predictable business expenses.
- If the individual or family has not had self-employment income for the past year, average the income over the period of time the business has been in operation and project the income for one year.
- If the business is newly established and there is insufficient information to make a reasonable projection, calculate the income based on the best available estimate and follow-up at a later date.
- A signed statement from individuals who are self-employed and have no documentation of their income will be accepted for a period of six (6) months. NBS Benefits coverage cannot be extended on subsequent applications without formal documentation of self-employment income.

Seasonal Employment – Include the total income for the months worked in the overall calculation of income. The total gross income for the year can be verified by a letter from the individual's employer, if possible.

Employment Terminated/New Employment – When the individual has been terminated, resigned, or laid off, the income from that job will then be disregarded. When an individual has not yet received income for new employment, use the best estimate of the amount to be received. If telephone verification regarding new or terminated employment is made, it must be documented by the contractor on the NBS Benefits Program Application for Services.

Disability – The individual must submit a statement from his/her physician verifying the approximate length of disability or a letter from the company/program providing eligibility dates.

Statements of Support – Unless the person providing the support to the individual is present during the interview and has acceptable documentation of identity, a statement of support will be required. The Statement of Support is used to document income when

no supporting documentation is available or when income is irregular. If questionable, the contractor may document proof of identification such as a Texas driver's license, Social Security card, or a birth certificate of the supporter.

ELIGIBILITY DETERMINATION

Eligibility determination criteria are residence, income, and ineligibility for other programs providing the same services. The final determination of eligibility for benefits is made by the NBS Benefits Program using the information provided on the NBS Benefits Program Application, supporting documentation and, if necessary, information provided during an interview. The NBS Benefits Program must consider each eligibility factor and document the basis for the eligibility decision on the Application Form.

Upon approving an application, the NBS Benefits Program will review the *Statement of Applicant's Rights and Responsibilities*. The statement should then be signed by the applicant and staff representative, a copy given to the applicant, and a copy filed in the patient's medical record.

The applicant will be provided Notice of Eligibility stating that either the family or individual is:

- Eligible
  - The individual/family is eligible for assistance;
  - The date eligibility begins and expires; and
  - The services the individual/family is entitled to receive.
- Ineligible
  - The reason the application was denied;
  - The effective date of denial;
  - The individual's right to appeal; and
  - Referral to alternative agencies/programs for services.

Appeal of Eligibility Determination

If an applicant has been determined ineligible for benefits, and the applicant believes the information on which the decision was based was incorrectly considered, the individual may appeal to the NBS Benefits Program. Individuals may appeal the program's decision to deny services within 30 days after receiving a denial. Appeals and requests for hearings must be in writing and sent by certified mail. Failure to respond will be deemed a waiver of appeal.

Date Eligibility Begins

An individual is entitled to services beginning with the date the completed application was submitted, provided it is approved. The NBS Benefits Program will notify the client, coordinating provider and contractor of the eligibility determination.

Presumptive Eligibility

Individuals with ***an immediate medical need*** may receive benefits on a presumptive eligibility basis during a pending eligibility for benefits or another program. Presumptive

eligibility is effective for ***no more than 60 days*** from the first contact date by the provider. The individual should be at or below 350% of the FPL, a Texas resident, and have an immediate medical need as determined by the provider. The *Presumptive Eligibility Form* must be completed, signed and dated by the applicant and the coordinating provider. The form must be sent/faxed to the NBS Benefits Program, and a copy retained in the patient's record. An individual shall be enrolled on a presumptive eligibility basis only once in a 12-month period.

If the individual has not completed or began the application process for the NBS Program Benefits or another program, the application process should occur during the time the individual is receiving services. If it is not medically possible, the contractor/coordinating provider will contact the NBS Benefits Program staff. The NBS Benefits Program staff will complete the eligibility process. If services are needed immediately and are not provided by another benefits program, services may be provided through the NBS Benefits Program during this 60-day period. If the individual becomes Medicaid or CHIP eligible, the services must be billed to Medicaid or CHIP under the 60 days prior provision. The NBS Benefits Program staff should be notified of the change in an individual's eligibility status on a timely basis.

A Presumptive Eligibility Form and Statement of Applicant's Rights and Responsibilities must be completed when an individual is determined presumptively eligible.

Applicants Screened Potentially Eligible for Other Benefits
Contractors should ensure that individuals seeking NBS Benefits Program services use other programs or benefits first. If individuals are determined potentially eligible for other benefits, contractors should refer them to the specific programs and assist them in completing the eligibility determination process. It is possible that a family will be referred to several programs as a result of the eligibility determination process. Programs/benefits that must be used first include:

- Private/Employer Insurance
- Medicare
- Medicaid
- TRICARE
- County Indigent Health Care Program (CIHCP)
- Children with Special Health Care Needs Services Program
- CHIP (other than family planning services)
- Title X, Title XIX (including the Women's Health Program) and Title XX Family Planning
- Breast and Cervical Cancer Services
- Worker's Compensation
- Veteran's Administration Benefits
- CHIP Perinatal Program

Individuals potentially eligible for Medicaid or CHIP should be referred to http://www.chipmedicaid.org or 1-877 KIDS NOW to request an application. They may also be referred to Your Texas Benefits website

(http://www.yourtexasbenefits.com) or 2-1-1 for comprehensive Medicaid or CHIP eligibility determination.

More information is available online at the following Internet address: http://www.CHIPmedicaid.org. CHIP Perinatal Program applications are available at HHSC benefits offices, participating community-based organizations, and online at http://www.yourtexasbenefits.com. A supply of applications can be ordered at http://www.chipmedicaid.com/cbo/application.htm. Individuals can also call 1-877-KIDSNOW or 1-877-543-7669 to get an application or apply online at http://www.CHIPmedicaid.org. Contractors must assist Individuals in completing the CHIP, Children's Medicaid, and CHIP Perinatal Application.

Individuals who are determined potentially eligible for another program (Medicaid, CHIP etc.) but fail to fully complete the required application process for that benefit program will not be eligible to receive NBS Benefits Program funded services beyond those services delivered during the presumptive eligibility period. If an Individual fails to complete the eligibility determination process for another benefit program, the contractor may bill NBS Benefits Program for the services delivered during the presumptive eligibility period only. Contractors should make Individuals aware that failing or refusing to complete the appropriate eligibility determination processes will result in their determination as self-pay clients. A copy of the NBS Benefits Program Application for Services or other form that documents that the individual was not potentially eligible for another program must be maintained in the medical record.

Annual Renewal
Eligibility for benefits will be determined by the NBS Benefits Program for each client **at least once every 12 months**.

Eligibility determination also will be repeated upon the occurrence of any factor impacting eligibility, such as a change in family composition or income, but must be repeated no less than annually for a client to continue to receive benefits.

A copy of the letter of eligibility or denial and any updated information obtained by the NBS Benefits Program will be sent to the contractor/coordinating provider, and must be retained in the client's file.

Procedures for Renewal
The contractor will determine the system used to track client status and renewal of eligibility.

For each client being re-certified, the contractor will assure the client completes a new NBS Benefits Program Application for Services. In so doing, the client:

- Updates/verifies information regarding family composition, residency, and income;
- Reviews and signs a new Statement of Applicant's Rights and Responsibilities;

- Is notified of the eligibility determination.

The contractor will assist clients who request help in completing forms or providing documentation. The contractor will retain copies of signed forms and copies of documentation in the client's record.

At least 30 days prior to the anniversary of their original eligibility date, NBS Benefits Program clients must be notified that they must renew eligibility by their anniversary date or lose their benefits until they are re-certified by the program. If renewal has not been completed by the anniversary date, the individual/family record should be removed from active status and placed in the inactive files. The individual/family should be notified of the status change. An individual can be a new client only once. Regardless of the time lapse between the initial application and the renewal application, former clients will not be classified as new.

Waiver of Ineligibility

Individuals that are covered by private medical insurance or other program (Medicaid, CHIP, etc.) may apply for a waiver of ineligibility if the other medical program denies coverage of a NBS Benefits Program service. The contractor must first bill the other medical program and only after the coverage is denied can the individual apply for the waiver. The contractor should assist the individual in completing, signing and submitting the NBS Benefits Program Application, the Waiver of Ineligibility Application and Statement of Applicant's Rights and Responsibilities Form to the NBS Benefits Program for eligibility determination.

MANDATORY DOCUMENTATION FOR CONTRACTORS

Each client must have a case record with documentation of eligibility for benefits.

The client's record must contain the following eligibility documentation:

- A copy of the appropriate completed and signed application form (NBS Benefits Program Application for Services, and Presumptive Eligibility) with a copy of the eligibility letter with the decision notated from the NBS Program staff;
- Copies of all prescription forms (metabolic formulas, vitamins, meds, and low-protein foods);
- Copies of acceptable documentation establishing family composition, residency and income;
- Copies of denial letters from other programs, if applicable;
- A copy of the signed Statement of Applicant's Right and Responsibilities; and
- Documentation of reported changes in the client's family composition, residency or income and its impact on eligibility, when applicable.

Records Retention

The contractor is responsible for maintaining copies of all quarterly Client Procedure Reports and Productivity Reports as well as client records per the record retention contractual requirements. The NBS Benefits Program will maintain records documenting eligibility for four state fiscal years following the end of the contract term during which the records were created.

Confidentiality and Privacy

The contractor is responsible for ensuring that files and medical records are maintained in a secure location and that information gathered verbally or in writing remains confidential. Those staff members having access to client records should ensure that information in those records is kept confidential. In addition, the contractor must ensure that services are provided in a confidential setting. Employees should be aware that violation of the law in regard to confidentiality might result in civil damages and criminal penalties.

SECTION II: ELIGIBILITY FORMS AND INSTRUCTIONS

NBS BENEFITS PROGRAM APPLICATION FOR SERVICES INSTRUCTIONS

The NBS Benefits Application For Services is used to screen, determine potential eligibility, and document eligibility determination for medical services assistance programs, such as Medicaid, Children's Health Insurance Program (CHIP), Title V Genetic Services, NBS Benefits Program, or other funding sources. The form does not determine final eligibility or ineligibility for any programs other than NBS Benefits Program. Applicants must be referred to other programs, such as Medicaid and CHIP, to determine eligibility and apply for services.

Instructions for Completing the NBS Application For Services

To the greatest extent possible, the application should be completed, signed and dated by the applicant, or the applicant's representative.

1. The family composition chart should reflect a group of people who live together, with one or more of the persons being legally responsible for support of the other person(s). The needs, income, resources, and medical expenses of anyone in the budget group are considered in determining eligibility for the group. For the purposes of this screening tool, consider only the parent(s), caretaker, spouse, and children under age 18 who live together as a family. (See Section 1 of manual for more information on family composition).
2. The income chart should include any type of payment that is of gain to the family.

3-4. These questions collect information on other benefits received, as well as pregnancy status, to assist NBS Benefits Program staff in determining potential eligibility.

Instructions for Completing the Statement of Applicant's Rights and Responsibilities

1. Applicant reads the Statement of Applicant's Rights and Responsibilities.
2. Applicant signs and dates the Statement of Applicant's Rights and Responsibilities.
3. Contractor signs as witness to the applicant's signature.

Eligibility Items:

- Family Composition: Enter number of family members in each of the categories listed. Enter total number of family members in bolded box. Note type of documentation on form. Attach documentation.

- Residency: Incorporated into family composition chart. An "eligible alien" is a person who is not a US citizen, but has immigration documents. "Other person" may be an individual who is not a US citizen and has no immigration documents. Note type of documentation on form. Attach documentation.

- Income: Income is any type of payment that is of gain to a family. Income may be earned or unearned. Earned income is defined as gross monthly income received for a certain degree of activity or work. Unearned income includes payments received without performing work-related activities, including benefits from other programs such as Social Security, VA benefits, TANF, or unemployment. If actual or projected income is not received monthly, convert it to monthly using one of the following methods:

    - If paid weekly, multiply weekly salary by 4.33.
    - If paid every two weeks, multiply salary by 2.17.
    - If paid twice a month, multiply salary by 2.

    - Childcare expenses may be deducted from total income. Allowable deductions are actual expenses up to $200 per dependent per month under 2 years of age and $175.00 per dependent per month for children age 2 to 12 (up to age 18 if the child is disabled).
    - The Grand Total Income (gross monthly income) is equal to Total Earned Income added to Total Unearned Income minus Total Childcare Expense Deduction(s).
    - Title V Genetic Services and NBS Benefits Program do not consider assets when determining eligibility, but assets are considered for Medicaid, CHIP, and CSHCN.

- Other Benefits: Other benefits may include Medicaid, Medicare, SSI, or County Indigent Program, for example. Contractor staff should note other benefits received and/or denied by applicant and family members.

- Special Circumstances: If Coordinating provider is assisting family with form, may document any special circumstances not already noted in this section, if applicable.

NBS BENEFITS PROGRAM APPLICATION FOR SERVICES

(To be completed by Applicant or parent/guardian)

Applicant Name / Solicitante /Nombre	**Date of Birth/**Fecha de nacimiento	**Home Phone No./**Teléfono de la casa	**County/**Condado
Mailing Address (Street or PO Box)/Dirección Postal (Calle o Apdo.)		**City/**Ciudad	**ZIP/**Zona Postal
Home Address, if different from above. Domicillio particular, si es diferente a la dirección de arriba.			
Diagnosis/Diagnostico:			
Physician Specialist's Name/Nombre de Especialista Doctoro		**What type of benefits are you requesting?**	

1. On the chart below, fill in the first line with information about applicant. Fill in the remaining lines for everyone who lives with you for which you are legally responsible. / En la tabla a continuación, llene la primera línea con información acerca de solicitante. Llene las líneas restantes acerca de todos que viven con usted y es legalmente oney sable.

Name Nombre	**Sex** Sexo **Male/Female** Hombre / Mujer	**Date of Birth** Fecha de nacimiento	**Texas Resident** Ciudadano de Texas **Yes/** Sí **or No**	**U.S. Citizen** Ciudadano de EEUU **Yes/** Sí **or No**	**What Relation to applicant?** ¿Parentesco con solicitante?
a.					**Applicant** Solicitante
b.					
c.					
d.					
e.					

2. ***Copies of paystubs that equal one month of pay must be submitted with this form.*** **List all of your household's income below. Be sure to include the following: Government checks; money from work; school scholarships; child support; workers compensation; disability benefits and unemployment.** Copias de los cheques que equivalen a un mes de pago debe ser presentado con este formulario. / Haga una lista de los ingresos de la unidad familiar a continuación. Asegúrese de anotar: Cheques del gobierno; ingresos de trabajo; becas de la escuela; manutención de niños, o pagos por desempleo.

Name of person receiving money Nombre de la persona que recibe el dinero	**Name of agency, person, or employer who provides the money** Nombre del patrón, la persona o la agencia que paga el dinero	**Amount received** Cantidad recibida	**How often received? (daily, weekly, every two weeks, monthly?)** ¿Con qué frecuencia lo recibe? (¿diariamente, por semana, cada quincena, una vez al mes?)

3. Do you, or does anyone in your household have any of the following? If yes, please circle which one:

¿ Usted o alguien en su familia tienen alguno de los siquentes? En caso affirmative, un ciruclo que:

Medicaid, Medicare, CHIP, health insurance, V. A., Tricare, Other If yes, please provide copy of your insurance card.
(seguro de salud) (administracion de los veteranos)

4. Are you – or is anyone in your household – pregnant? ¿Está usted o alguien de la unidad familiar embarazada?..... ….....☐**Yes**/Sí ☐**No**

If Yes, who?/Si contesta "Sí," ¿quién? _____

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

A mi leal saber y entender, las declaraciones que he hecho, y mis respuestas a todas las preguntas, son verdaderas y correctas. Me comprometo a dar al personal que verifica la elegibilidad toda la información necesaria para comprobar mis declaraciones sobre la elegibilidad. Yo entiendo y acepto que al proporcionar información falsa puede resultar in que yo no califique y que tenga que devolver el pago al Programa.

Signature – Applicant / Firma – Solicitante	**Date** / Fecha	**Signature – Applicant's Representative**	**Date** / Fecha

STATEMENT OF APPLICANT'S RIGHTS AND RESPONSIBILITIES

DECLARACIÓN DE LOS DERECHOS Y DEBERES DEL SOLICITANTE

By signing this application for assistance, I affirm the following:	Al firmar esta solicitud para recibir asistencia, yo afirmo lo siguiente:
The information on the application and its attachments is true and correct. This application is a legal document. Deliberately omitting information or giving false information may cause the Provider to terminate services to a member of my household/family or me.	La información escrita en la solicitud y en sus anexos es verdadera y correcta. Esta solicitud es un documento legal. El deliberadamente omitir información o el proporcionar información falsa podría dar lugar a que el Proveedor cancele los servicios a uno de los miembros de mi hogar, de mi familia o los míos propios.
If I omit information, fail or refuse to give information, or give false or misleading information about these matters, I may be required to reimburse the State for the services rendered if I am found to be ineligible for services. I will report changes in my household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency).	Si yo omito información, dejo de proporcionar o me niego a proporcionar información o; proporciono información falsa o engañosa acerca de estos asuntos, podría requerírseme que reembolse al Estado el costo de los servicios recibidos, si acaso se determina que no califico para los servicios. Yo reportaré los cambios en la situación de mi hogar, de mi familia, que afecten la elegibilidad durante el período de certificación (cambios en el ingreso, en los miembros del hogar, en la familia y, cambios de residencia.)
I authorize release of all information, including but not limited to, income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household/family or me.	Yo autorizo la divulgación de toda la información, incluyendo pero no limitada a, el ingreso y a la información médica, de parte de y para, el *Texas Department of State Health Services* (DSHS) *[Departamento Estatal de Servicios de Salud de Texas*] y, al Proveedor para poder determinar la elegibilidad, para poder cobrar o, proporcionar servicios en mi hogar, a mi familia o, a mí personalmente.
I understand I may be asked by Provider to provide proof of any of the information provided in this application.	Entiendo y acepto que podría pedirme el Proveedor que proporcione comprobantes de cualquiera de la información proporcionada en esta solicitud.
Health insurance coverage, including but not limited to individual or group health insurance, health maintenance organization membership, Medicaid, Medicare, Veterans Administration benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Worker's Compensation benefits, must be reported to Provider. Benefits from health insurance may be considered the primary source of payment for health care received. I hereby assign to Provider any such benefits. I also assign payment for benefits and services received from and through Provider directly to the service providers.	La cobertura de seguro de salud, incluyendo pero no limitada a seguro para un individuo o seguro de salud para un grupo de personas; los de membresía proporcionados por organizaciones para el mantenimiento de la salud [como HMO], *Medicaid*, *Medicare*; beneficios de la *Veterans Administration;* de la CHAMPUS y *Worker's Compensation* [beneficios de Compensación Laboral], deben ser reportados al Proveedor. Los beneficios provenientes de esos seguros de salud pudieran ser considerados como la fuente principal de pago de la atención de salud recibida. Por este medio yo, asigno al Proveedor cualquiera de dichos beneficios. También asigno el pago de los beneficios y servicios recibidos de parte de y, a través del Proveedor, directamente a los proveedores de servicios.
I understand that, to maintain program eligibility, I will be required to reapply for assistance at least every twelve months.	Yo entiendo y acepto que, para mantener la elegibilidad para el programa, se me va a requerir que vuelva a solicitar para recibir asistencia, por lo menos cada doce meses.
I am a bona fide resident of Texas or a dependent. I physically live in Texas, maintain living quarters in Texas, and do not claim to be a resident of another state or country, or am a dependent of a bona fide Texas resident.	Soy residente legítimo de Texas o bien, dependiente del territorio. Yo vivo físicamente en Texas, mantengo residencia en Texas y, no afirmo ser residente de otro estado o país o bien, soy un dependiente de un residente legítimo de Texas.
Some programs provide care through program-approved providers. I understand that, to receive benefits from such programs, treatment must be received through those program-approved providers.	Algunos programas proporcionan atención a través de proveedores aprobados por los programas. Yo entiendo y acepto que, para recibir beneficios de dichos programas, el tratamiento debe ser recibido a través de esos proveedores aprobados por el programa.
I understand that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.	Yo entiendo y acepto que el criterio para la participación en el programa es el mismo para todos sin importar sexo, edad, discapacidad, raza o bien, origen de nacionalidad.
I understand I have the right to file a complaint regarding the handling of my application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.	Yo entiendo y acepto que tengo el derecho de registrar una queja con relación al manejo de mi solicitud o con relación a cualquier acción tomada por el programa con HHSC Civil Rights Office de 1-888-388-6332.
I understand that I will receive written documentation concerning the services for which my household/family or is eligible or potentially eligible.	Yo entiendo y acepto que recibiré documentación por escrito concerniente a los servicios para los cuales mi hogar, mi familia o yo calificamos o, potencialmente lleguemos a calificar.
With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us **for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)**	Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 552.021, 522.023 y 559.004)
I understand and agree that the program does not provide payment for inpatient care. I understand that I must make my own arrangement for hospital care and that I am responsible for the cost of the care.	Entiendo y acepto que el programa no proporciona pago por la atención de pacientes internos. Entiendo y acepto que yo debo hacer mis propios arreglos de atención en el hospital y que yo soy responsable por el costo de la atención.
Signature – Applicant / Firma – Solicitante **Date** / Fecha	**Staff Signature, if applicable** **Date**

TEXAS Department of State Health Services

Fax completed form to Benefits Program: 512-776-7593

NEWBORN SCREENING BENEFITS PROGRAM PRESCRIPTION FORM

Date: _____ Spanish Speaking Only: ☐ YES ☐ NO

Applicant's Name: _____ ☐ **NEW APPLICANT** ☐ **RENEWAL CLIENT**

Applicant's diagnosis: _____

Parent/Guardian: _____ Telephone #: _____

DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

Ship to address if different from above: _____

_____

E-mail Address: _____

Waiver of Ineligibility

Please fill out this portion if you have insurance, Medicaid, Medicare, etc

Medicaid/Medicare: ☐ YES ☐ NO If yes, give # _____

Private Insurance OR Private Pay? ☐ Name of Insurance _____
☐ Private Pay

Give explanation why you are requesting NBS Benefits services: _____

_____

CONTRACT STAFF ONLY:

Low Protein Food: ☐ YES ☐ NO

☐ PKU Perspectives **OR** ☐ Cambrooke Foods

Pharmacy: ☐ YES ☐ NO Pick one:

☐ Davila ☐ Aapex ☐ Quick Mesa

Medications & Vitamins: _____

Contracted Provider/Facility: _____

Name of Dietitian: _____ Telephone #: _____

Staff Signature: _____ Date: _____

NBS BENEFITS ONLY: Approved: ☐ YES ☐ NO

NBS Benefits Signature: _____ Date: _____

If requesting medications and/or vitamins not in NBS Benefits Manual:

Approved: ☐ YES ☐ NO

NBS Physician Signature: _____ Date: _____

TEXAS Department of State Health Services

NEWBORN SCREENING BENEFITS PROGRAM
ADDITIONAL PRESCRIPTION REQUEST

(current clients only)

Date: _____

Client's Name: _____

DOB: _____

Pharmacy client is currently on: ☐ Davila ☐ Aapex ☐ Quick Mesa

Medications & Vitamins: _____

_____

Contracted Provider/Facility: _____

Name of Dietitian: _____ Telephone #: _____

Staff Signature: _____ Date: _____

NBS BENEFITS ONLY: Approved: ☐ YES ☐ NO

NBS Benefits Signature: _____ Date: _____

If requesting medications and/or vitamins not in NBS Benefits Manual:

Approved: ☐ YES ☐ NO

NBS Physician Signature: _____ Date: _____

*****Please fax prescription along with this form to:***

NBS Benefits Program
ATTN: Henrietta Jimenez
512-776-7593

TEXAS Department of State Health Services

NEWBORN SCREENING BENEFITS PROGRAM
LOW PROTEIN FOOD REQUEST
(current clients only)

Date: _____

Client's Name: _____

DOB: _____

Client is currently with: ☐ Davila **OR** ☐ Aapex **OR** ☐ Quick Mesa

Please choose Low Protein Food Manufacturer:

☐ PKU Perspectives **OR** ☐ Cambrooke Foods

Contracted Provider/Facility: _____

Name of Dietitian: _____ Telephone #: _____

Staff Signature: _____ Date: _____

NBS BENEFITS ONLY: Approved: ☐ YES ☐ NO

NBS Benefits Signature: _____

Date: _____

*****Please fax prescription along with this form to:***

NBS Benefits Program
ATTN: Henrietta Jimenez
512-776-7593

PRESUMPTIVE ELIGIBILITY INSTRUCTIONS
(For Immediate Medical Needs)

PURPOSE

The Presumptive Eligibility Form should be completed when an applicant is in need of immediate medical services and cannot fulfill application requirements at the time. The purpose of the form is to document that an applicant appears to be eligible for benefits. The eligibility determination process will be completed as soon as the applicant is able, and within 60 days following the delivery of services.

PROCEDURE

When to prepare: complete for persons who are in need of immediate medical services, but time or lack of materials prevent screening and eligibility determination.

Number of copies: complete an original and keep a copy for your records.

Transmittal: give a copy of the form to the applicant with NBS Benefits Program contact information in order to complete the application process. Mail/fax the completed form with the signed Statement of Applicant's Rights to the NBS Benefits Program. Maintain copies of the forms in the client's chart.

Form retention: keep the case record copy for four state fiscal years after services are rendered.

INSTRUCTIONS FOR COMPLETING THE FORM

- Enter applicant name, name of legally responsible adult if applicant is a child, address and phone number where applicant (legally responsible adult) can be reached, date of birth, mailing address.
- Enter physician specialist's name and phone number.
- Enter the type of benefits requested (i.e. metabolic food or medication)
- Applicant completes numbers 1 through 7.
- Applicant and coordinating provider signs and dates the Presumptive Eligibility Form.
- Print name of the contractor (i.e., metabolic specialist, endocrinologist or hematologist responsible for providing services to the individual).
- Applicant and coordinating provider (i.e., contractor, nutritionist, nurse, or social worker) sign the Statement of Applicant's Rights and Responsibilities.
- Copies of the signed forms are provided to the applicant. The original completed/signed Presumptive Eligibility Form and the Statement of Applicant's right is mailed/faxed to the NBS Benefits Program. Copies of the signed forms are kept in the applicant's record.

Mail/fax to:
NBS Benefits Program
MC 1918
P.O. Box 149347
Austin, TX 78714-9347
FAX: 512-776-7593

If applicant is approved for an immediate medical need, NBS Benefits Program contacts the provider. The provider then faxes a completed Metabolic / Immediate Medical Need Prescription Request to the NBS Benefits Program at the fax number above. NBS Benefits Program submits the prescription to the pharmacy.

PRESUMPTIVE ELIGIBILITY APPLICATION

Name/Nombre	Home Telephone/Número de teléfono de la casa **(If no phone, give number of person who can reach applicant/**de no tener teléfono, proporcione el teléfono de la persona que pueda ponerse en contacto con el solicitante)
Date of birth/ Fecha de nacimeinto	Mailing Address (Street or P.O. Box)/**Dirección Postal (Calle o Apdo.)**
City/Ciudad ZIP/ **código postal**	**Home Address, if different from above.** Domicillio particular, si es diferente a la dirección de arriba.
Physician Specialist Name/Nombre de Especialista Doctoro	**Telephone Number**/Numero de teléfono
What Benefits are you requesting?	

I am in need of immediate medical benefits (medical foods, medications) from the Newborn Screening Benefits Program. I understand that within 60 days following the delivery of services, I will submit a completed application for eligibility determination. The information below is true, correct, and complete to the best of my knowledge.
(Estoy en necesidad inmediata de beneficios del Programa de Examen Médico de Recién Nacidos (medicos alimientos, medicamentos). Yo entiendo y acepto que dentro de 60 días después de recibir los servicios yo entregaré una solicitud completamente llena, para que se lleve a cabo la determinación de elegibilidad. La información arriba proporcionada es verdadera, correcta y completa según mi leal saber y entender.

1. **Are you or the person applying for services a resident of Texas? ☐Yes/Si ☐No**
   (¿Son residentes de Texas, usted o la persona que solicita servicios?)

2. **I am eligible for Medicaid (if under age 21 yrs.) ☐ Yes/Si ☐No**
   (Soy elegible para Medicaid (si es menor de 21 anos de edad)

3. **I am eligible for Children's Health Insurance Program (CHIP) ☐ Yes/Si ☐ No**
   (Soy elegible para el Programa de Seguro Médico para Niños) (CHIP)

4. **I am eligible for Children with Special Health Care Needs (CSHCN) ☐ Yes/Si ☐ No**
   (Soy elegible para el Programa de Niños con Necesidades Especiales de Salud) (CSHCN)

5. **I have insurance (or HMO/PPO) coverage for formula ☐ Yes/Si ☐ No**
   (Tengo seguro (o HMO / PPO) para la cobertura de formula)

6. **I have a gross family income at or below 350% of the most current Federal Poverty Level guidelines. ☐Yes/Si ☐No**
   (Tengo un ingreso familiar bruto igual o inferior al 350% de los más actuales lineamientos del Nivel Federal de Pobreza)

7. **I was not able to complete the eligibility determination process for the Program at this time. ☐Yes/Si ☐No**
   (En este momento, no me fue posible completar el proceso de determinación de elegibilidad para el Programa).

I understand that I will be contacted by the Department of State Health Services Newborn Screening Program within 60 days to complete a *NBS Benefits Program Application for Services for Services Assistance.*
(Yo entiendo que seré contactado por el Programa de Examen Médico de Recién Nacidos del Departamento Estatal de Servicios de Salud dentro de 60 días para completar un formulario de selección y elegibilidad para servicios de asistencia.)

Signature – Applicant / Firma – Solicitante	**Date** / Fecha
Print Name of Contractor:	**Date** / Fecha
Signature – Contractor Staff / Firma – Oficinista	
Phone: **Fax:**	

Approved by NBS Representative Signature:_____ Date: _____

TEXAS Department of State Health Services

NEWBORN SCREENING BENEFITS PROGRAM
METABOLIC / IMMEDIATE MEDICAL NEED PRESCRIPTION REQUEST

Date_____

Applicant's Name: _____

Parent/Guardian: _____

Spanish Speaking Only: ☐ YES ☐ NO

DOB: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ Zip: _____

Current Telephone #:_____

Ship to address if different from above: _____

_____

Name of metabolic food: _____ Other Medical Need:

Quantity (2 month supply): _____ (list # cases) _____

Flavor (if applicable):_____ _____

Pharmacy: ☐ Davila ☐ Aapex ☐ Quick Mesa

Applicant's diagnosis: _____ ICD-9 Code: _____

Printed name of Specialist: _____

Staff Signature: _____ Date: _____

Telephone #: _____

Name of person completing form: _____

Title: _____

Fax completed form to Benefits Program: 512-776-7593

SECTION III: ALLOWABLE NBS BENEFITS

ALLOWABLE BENEFITS OVERVIEW

NBS Benefits Program contractors shall provide or assure the provision of benefits to include confirmatory testing, follow-up care, and remediation services for eligible clients. Confirmatory testing is indicated when an individual has a positive presumptive screen of a disorder screened by the NBS Program. Components include patient evaluation, one or more supplemental laboratory tests to substantiate or refute results of the screen, and if confirmed, management of the disorder. Remediation services include those dietary supplements, vitamins, and medications prescribed by the provider and deemed necessary for the treatment and management of the diagnosed disorder.

This section of the manual lists allowable services and procedure codes per procedure.

EVALUATION AND MANAGEMENT

Evaluation and management benefits are based on Medicaid established rates and limitations.

New Patient Office Visit

Physicians may use procedure codes 99201 through 99205 when billing for new patient services provided in the office, or in an outpatient or other ambulatory facility. Components include problem focused patient/family history, physical examination, and medical decision-making, with increasing levels of complexity and physician time with the patient and family. Below is the list of the standard New Patient Office Visit codes:

Codes
99201
99202
99203
99204
99205

Established Patient Office Visit

Physicians may use procedure codes 99211 through 99215 when billing for established patient services provided in the office, or in an outpatient or other ambulatory facility. Below are the standard Established Patient Office Visit codes:

Codes
99211
99212
99213
99214
99215

New or Established Patient Office Consultation

Physicians may use procedure codes 99241 through 99245 when billing for new or established patient consultation provided in the office, or in an outpatient or other

ambulatory facility. Below are the standard Established Patient Office Consultation codes:

Code
99241
99242
99243
99244
99245

Medical Geneticist (Provider type 68) Visit/Consultation
Medicaid genetic codes can be used for reimbursement by medical geneticists (type 68 provider). The allowable codes are: 99245-TG, 99244-TG, and 99214-TG.

Specialist Telephone Consultations
Telephone consultations are considered a benefit if the clinician providing the client's medical home contacts a specialist for advice or a referral. The telephone consultation must be at least 15 minutes in duration. During the telephone call, the specialist assesses and manages the client's care by providing advice or referral to a more appropriate provider.

The following procedure code must be used with modifier U9 for a specialist telephone consultation.

Procedure Codes	
Procedure Code	**Description**
3-99499	Unlisted evaluation and management service (15 minutes)

Modifier	
Modifier	**Description**
U9	State Defined Modifier: Specialist telephone consultation

A specialist telephone consultation (procedure code 3-99499 with modifier U9) is limited to two consultations every six months. The specialist providing consultation, but not the clinician providing the medical home, will be reimbursed for consultation (note: the two allowable charges per six months are for each client by the same specialist).

Specialist Telephone Consultation Form for Non-Face-to-Face Clinician-Directed Care Coordination Services

Newborn Screening Benefits Program

(Specialist must keep copy on file)	
Client name:	Time call started:
Date of birth: ____/____/_____	Time call ended:
Parts A and B of this form must be completed and the form retained in the specialist's records.	
Part A	
Reason for call:	
The specialist's medical opinion:	
Recommended treatment or laboratory services:	
Physician's signature:	Date: ____/____/_____
Physician name:	Physician's fax number:
Part B	
Referring medical home clinician:	Referring clinician's telephone number:

Instructions for Completion of the Specialist Telephone Consultation Form
The specialist must complete the Specialist Telephone Consultation Form and maintain supporting documentation in their records. The Specialist Telephone Consultation Form must be signed and dated by the specialist and must include the following information:

- Client's name, date of birth;
- Start and stop times indicating the consultation lasted at least 15 minutes;
- The reason for the call;
- The specialist's medical opinion;
- The recommended treatment and/or laboratory services;
- The name and telephone number of the referring clinician providing the medical home;
- The specialist's and referring clinician's identifier information;
- The name of the consulted specialist.

The specialist will submit the Specialist Telephone Consultation Form with a State of Texas Voucher for each client consultation provided per month (Section 4: Billing and Reporting).

LABORATORY PROCEDURES

As funding allows, the NBS Benefits Program offers reimbursement to enrolled laboratories for the provision of specified services at Medicaid reimbursement rates or the established rates as outlined below. Any test over $400.00 must have prior of approval from the NBS Benefits Program.

Metabolic Disorders

Laboratory Test	Laboratory Rate
Urine acylglycines	
Urine amino acids	$115.18
Urine galactitol	
Urine homocysteine	
Urine quantitative organic acids	$129.87
Urine succinylacetone	$137.76
Plasma acylcarnitines	
Carnitine Combination Analysis (Acylcarnitines Profile and Total Carnitine)	$128.83
Plasma Dried Blood Spot Acylcarnitines	$77.00
Plasma quantitative amino acids	$95.00
Glutaric acid	
Plasma ammonia	
Plasma carnitine	
Plasma Carnitine Free and Total	$113.83
Dried Blood Spot Carnitine Levels	$50.00
Plasma galactose	
Plasma homocysteine	
Plasma Homocysteine and Methionine	$100.54
Plasma Total Hhomocysteine	$35.00
Plasma lactate/lactic acid	
Plasma methionine	
Plasma phenylalanine	$92.11
Plasma tyrosine	
Isoleucine challenge	
C16 and BCAA cell probes	
C16 and C18:1 cell probes	$723.00*
RBC Gal-1-P	
WBC carnitine uptake	
DNA (A985G+ plus selected mutations) – MCAD	$296.30
DNA – IVD and SBCAD	
DNA sequencing – MCAD	$434.04*
DNA – fumaryl acetoacetate hydrolase	$483.64*
DNA – phenylalanine hydroxylase	$520.30*
DNA – GALT	
DNA sequencing – LCHAD	$637.79*
DNA (1528) – LCHAD	$245.29
DNA – MSUD	$531.94*
Enzyme – GALT – quantitative	$123.52
Enzyme – MSUD - BCKD	
Enzyme – skin biopsy – MCAD	

Enzyme – 3OH-3CH3 glutaryl CoA lyase	
Enzyme assay RBC arginase	$117.52
Enzyme – skin biopsy – methylmalonyl CoA mutase	
Enzyme – skin biopsy - MCC	
Enzyme – propionyl CoA caboxylase	
Enzyme – skin biopsy – glutaryl CoA dehydrogenase	
Enzyme – skin biopsy – long chain hydroxy acyl-CoA thiolase	
Enzyme – skin biopsy – long chain 2-enoyl-CoA hydratase	
Enzyme – skin biopsy – VLCAD	
Enzyme – skin biopsy – LCHAD	
Enzyme – WBC – holocarbxylase synthetase	
Enzyme – skin biopsy – propionate incorporation studies	
Enzyme – skin biopsy – propionate incorporation studies and complementation analysis	
Enzyme – skin biopsy – BKT	
Enzyme – liver biopsy – argininosuccinate synthetase assay	$203.72
Enzyme – biotinidase	$105.52
Enzyme - fumarylacetoactase	

Cystic Fibrosis

Laboratory Test	Laboratory Rate
CFTR Sequencing Analysis	$659.36*

Endocrine Disorders

Laboratory Test	Laboratory Rate
T4	
Free T4	
TSH	
17-OH progesterone	
Electrolytes	
ACTH stimulation test	
Pregnanetriol	
ACTH	

Hemoglobin Disorders

Laboratory Test	Laboratory Rate
CBC	
Iron	
Liver function	
Hemoglobin electrophoresis	

*Any test over $400.00 must have prior of approval from the NBS Benefits Program.

Other laboratory procedures will not be reimbursed unless prior approval is obtained from the NBS Program.

REMEDIATION SERVICES

Upon receipt of the eligible client's completed/approved Newborn Screening Benefits Program Application for Services, the NBS Benefits Program will send the applicant and coordinating provider a letter outlining the eligible benefits.

Following are lists of medications, dietary supplements, and vitamins indicated for the various 28 disorders. The physician provider will determine the course of treatment for dietary supplements, medications, and vitamins; **the lists are provided for reference only.** This program does not cover DME's (e.g. syringes, needles, and test strips).

The provider is responsible for prescribing needed remediation services. The patient is responsible for procuring the prescribed medications, vitamins, and/or formula.

Dietary supplements, Medications and Vitamins

Dietary supplements are prescribed by a physician when a patient has special nutrient needs in order to manage a disease or health condition, and the patient is under the physician's ongoing care. The label must clearly state that the product is intended to be used to manage a specific medical disorder or condition.

Dietary supplements are not meant to be used by the general public and may not be available in stores or supermarkets. Dietary supplements are not those foods included within a healthy diet intended to decrease the risk of disease, such as reduced-fat foods or low-sodium foods, nor are they weight loss products.

Dietary supplements are reimbursable at whole sale cost plus 15%.

There is a limit of $1500.00 per month per client for dietary supplements.

There is a limit of $300.00 per month per client for vitamins.

Amino Acid Disorders

DISORDER	FORMULA/MEDICATION/VITAMINS	MANUFACTURER
Homocystinuria	Hominex-1	Abbott Nutrition
	Hominex-2	Abbott Nutrition
	HCY 1	Mead Johnson
	HCY 2	Mead Johnson
	HOM 2	Milupa
	XMet Analog	Nutricia
	XMet Maxamaid – orange flavor	Nutricia
	XMet Maxamum – orange flavor	Nutricia
	HCU Gel	Vitaflo
	HCU Express	Vitaflo
	Pro-Phree	Abbott Nutrition
	Super Soluble Duocal	Nutricia
	PFD 1	Mead Johnson
	PFD 2	Mead Johnson
	Cystine AA Supplement	Vitaflo
	Pyridoxine Tablets (50 mg)	
	Cystadane Powder (Betaine)	
	Cyanocobalamin (vitamin B12)	
MSUD (Maple Syrup Urine Disease)	MSUD Analog	Nutricia
	MSUD Maxamaid – orange flavor	Nutricia
	MSUD Maxamum – orange flavor	Nutricia
	Acerflex – pineapple flavor	Nutricia
	MSUD 2	Milupa
	BCAD 1	Mead Johnson
	BCAD 2	Mead Johnson
	Ketonex-1	Abbot Nutrition
	Ketonex-2	Abbott Nutrition
	Complex MSUD Drink Mix – vanilla	Applied Nutrition
	Complex MSUD Amino Acid Bar – chocolate	Applied Nutrition
	Complex MSUD Amino Acid Blend	Applied Nutrition
	MSUD Gel	Vitaflo
	MSUD Express	Vitaflo
	MSUD Express Cooler	Vitaflo
	MSUD Amino Acid Mix	Applied Nutrition
	Pro-Phree	Abbott Nutrition
	PFD 1	Mead Johnson
	PFD 2	Mead Johnson
	Super Soluble Duocal	Nutricia
	Alanine AA	
	Isoleucine AA Supplement	
	Valine AA Supplement	
	Thiamine	
Phenylketonuria - PKU	Phenex-1	Abbott Nutrition
	Phenex-2	Abbott Nutrition
	Phenex-2 – vanilla	Applied Nutrition
	PhenylAde Drink Mix – vanilla	Applied Nutrition
	PhenylAde Drink Mix – orange creme	Applied Nutrition
	PhenylAde Drink Mix – vanilla strawberry	Applied Nutrition
	PhenylAde Drink Mix – chocolate	Applied Nutrition
	PhenylAde 40 Drink Mix – unflavored	Applied Nutrition
	PhenylAde 40 Drink Mix – citrus	Applied Nutrition
	PhenylAde 60 Drink Mix – Vanilla	Applied Nutrition

	PhenylAde Essential Drink Mix – Chocolate	Applied Nutrition
	PhenylAde Essential Drink Mix – Orange Crème	Applied Nutrition
	PhenylAde Essential Drink Mix – Strawberry	Applied Nutrition
	PhenylAde Amino Acid Blend	Applied Nutrition
	PhenylAde MTE Amino Acid Blend	Applied Nutrition
	PhenylAde Amino Acid Bar – chocolate	Applied Nutrition
	PhenylAde Amino Acid Bar – chocolate crispy	Applied Nutrition
	PhenylAde Amino Acid Bar – white chocolate	Applied Nutrition
	PhenylAde Phebloc Tablet	Mead Johnson
	Phenyl-Free 1	Mead Johnson
	Phenyl-Free 2	Mead Johnson
	Phenyl-Free 2HP	Milupa
	PKU 2	Milupa
	PKU 3	Solace Nutrition
	PreKUnil	Solace Nutrition
	Neophe	Nutricia
	XPhe Maxamaid – unflavored	Nutricia
	XPhe Maxamaid – orange	Nutricia
	XPhe Maxamaid – strawberry	Nutricia
	XPhe Maxamum – unflavored	Nutricia
	XPhe Maxamum – orange	Nutricia
	XPhe Maxamum Drink in a tetra pak	Nutricia
	Periflex – orange-pineapple	Nutricia
	Periflex – chocolate	Nutricia
	Xphe Analog	Nutricia
	Phlexy-10 Drink Mix – tropical surprise	Nutricia
	Phlexy-10 Drink Mix – black currant/apple	Nutricia
	Phlexy-10 Bar	Nutricia
	Phlexy-10 Capsules	Nutricia
	Phlexy-10 Tablets	Nutricia
	Lophlex Drink Mix – berry	Nutricia
	Lophlex Drink Mix – orange	Vitaflo
	PKU Gel	Vitaflo
	PKU Express	Vitaflo
	PKU Express Cooler	
Tyrosinemia, Type II	Tyrex-1	Abbott Nutrition
	Tyrex-2	Abbott Nutrition
	XPhe, XTyr Analog	Nutricia
	XPTM Analog	Nutricia
	XPhe, XTyr Maxamaid	Nutricia
	TYR 2	Milupa
	TYROS 1	Mead Johnson
	TYROS 2	Mead Johnson
	TYR Gel	Vitaflo
	TYR Express	Vitaflo
	Vitamin D	
	Nitisinone (Orfadin) Tablets	
Urea Cycle Disorders (Citrullinemia, Argininosuccinic Acidemia)	Cyclinex-1	Abbott Nutrition
	Cyclinex-2	Abbott Nutrition
	Pro-Phree	Abbott Nutrition
	WND 1	Mead Johnson
	WND 2	Mead Johnson
	PFD 1	Mead Johnson
	PFD 2	Mead Johnson
	UCD 2	Milupa
	Super Soluble Duocal	Nutricia
	L-Citrulline	

	L-Arginine Amino Acid Mix, Essential Buphenyl Powder Buphenyl Tablets Sodium Benzoate Powder (Sectrum) Na Benzoate Powder Na Benzoate 10% Solution (100 mg/ml) Acetyl Carnitine L-Carnitine (100 mg/ml) Leucine Powder Isoleucine Powder Valine Powder Omeprazole Polycose Powder	 Ucyclyd Pharma Ucyclyd Pharma AstraZeneca

Organic Acidemias Disorders

DISORDER	FORMULA/MEDICATION/VITAMINS	MANUFACTURER
Beta-Ketothiolase Deficiency (BKT)	MSUD Analog MSUD Maxamaid – orange MSUD Maxamum – orange Acerflex – pineapple MSUD 2 BCAD 1 BCAD 2 Ketonex-1 Ketonex-2 Complex MSUD Drink Mix – vanilla Complex MSUD Amino Acid Bar – chocolate Complex MSUD Amino Acid Blend MSUD Gel MSUD Express MSUD Amino Acid Mix Pro-Phree PFD 1 PFD 2 Super Soluble Duocal Isoleucine AA Supplement Valine AA Supplement	Nutricia Nutricia Nutricia Nutricia Nutricia Mead Johnson Mead Johnson Abbott Nutrition Abbott Nutrition Applied Nutrition Applied Nutrition Applied Nutrition Vitaflo Vitaflo Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Glutaric Aciduria, Type I	Riboflavin Glutarex-1 Glutarex-2 Pro-Phree GA GA Gel - Unflavored PFD 1 PFD 2 Super Soluble Duocal XLys, XTrp Analog XLys, XTrp Maxamaid – orange XLys, XTrp Maxamum – orange Baclofen L-Carnitine Acetyl Carnitine	 Abbott Nutrition Abbott Nutrition Abbott Nutrition Mead Johnson Vitaflo Mead Johnson Mead Johnson Nutricia Nutricia Nutricia Nutricia Parchem
Holocarboxylase Synthetase Deficiency/ Múltiple Carboxylase	Biotin	

Deficiency		
Isovaleric Acidemia	I-Valex-1 I-Valex-2 XLeu Analog XLeu Maxamaid – orange XLeu Maxamum – orange LMD Pro-Phree PFD 1 PFD 2 Super Soluble Duocal L-Carnitine (100mg/ml) Acetyl Carnitine Glycine	Abbott Nutrition Abbott Nutrition Nutricia Nutricia Nutricia Mead Johnson Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Methylmalonic Acidemia/ Cobalamin A, B/ Homocystinuria	Propimex-1 Propimex-2 OA 1 OA 2 XMTVI Analog XMTVI Maxamaid – orange XMTVI Maxamum – orange Milupa OS 2 MMA/PA Gel MMA/PA Express Pro-Phree PFD 1 PFD 2 Super Soluble Duocal L-Carnitine (100 mg/ml) Acetyl Carnitine Hydroxocobalamin IM (1 mg/ml) Cyanocobalamin Tablets Cystadane (Betaine) – (1 gm/scoop)	Abbott Nutrition Abbott Nutrition Mead Johnson Mead Johnson Nutricia Nutricia Nutricia Nutricia Vitaflo Vitaflo Abbott Nutrition Mead Johnson Mead Johnson Nutricia
Methylmalonic Acidemia (Mutase Deficiency) - MUT	L-Carnitine Acetyl Carnitine Cyanocobalamin	
Propionic Acidemia	Propimex-1 Propimex-2 OA 1 OA 2 XMTVI Analog XMTVI Maxamaid – orange XMTVI Maxamum – orange MMA/PA Gel MMA/PA Express Pro-Phree PFD 1 PFD 2 Super Soluble Duocal Propionic Amino Acid Mix (TCH 92% AA) Leucine Powder Isoleucine Powder Valine Powder Biotin Acetyl Carnitine L-Carnitine	Abbott Nutrition Abbott Nutrition Mead Johnson Mead Johnson Nutricia Nutricia Nutricia Vitaflo Vitaflo Abbott Nutrition Mead Johnson Mead Johnson Nutricia

Fatty Acid Oxidation Disorders

DISORDER	FORMULA/MEDICATION/VITAMINS	MANUFACTURER
Carnitine Uptake Defect (CUD)	L-Carnitine Acetyl Carnitine	
MCAD	L-Carnitine Acetyl Carnitine	
Long-Chain Hydroxy-Acyl-CoA Dehydrogenase Deficiency (LCHAD)	L-Carnitine Acetyl Carnitine	
Trifunctional Protein Deficiency (TEP)	L-Carnitine Acetyl Carnitine	
Very-Long-Chain Acyl-CoA Dehydrogenase Deficiency (VLCAD)	MCT Oil L-Carnitine Acetyl Carnitine	
Biotinidase Deficiency	Free Biotin	
Galactosemia	Enfamil Prosobee Lipil Similac Isomil Advance Good Start Supreme Soy Parent's Choice Soy Infant Formula with a Blend of Lipids	Mead Johnson Abbott Nutrition Nestle PBM Nutritionals

Endocrine Disorders

DISORDER	MEDICATION	MANUFACTURER
Hypothyroidism	Synthroid Levothroid Levoxyl	Abbott Laboratories Forest Pharmaceuticals Jones Pharma
CAH	NaCl (salt) Cortisone Fluorinef	

Hemoglobin Disorders

DISORDER	TREATMENT
Sickling Hemoglobinopathies	Penicillin Oxygen IV Fluids Antibiotics Analgesics Hydroxyurea Desoferrin

Cystic Fibrosis Disorder

Vitamins/Formula/Medications	MANUFACTURER
AquADEK	Axcan Scandipharm, Inc
Source CF	Cardinal Health Pharmaceuticals
Vitamax	Natures Products
ADEK	Axcan Scandipharm, Inc
Vitamin D: D2/Drisdol and D3	
Vitamin E	
Vitamin K/Mephyton	Aton Pharma Inc
Calcium	
Pediasure/Pediasure Enteral	Abbott Nutrition
Ensure/Ensure Plus	Abbott Nutrition

Scandishakes	Axcan Scandipharm, Inc
Peptamen Jr	Nestle Nutrition
Peptamen Jr 1.5	Nestle Nutrition
TwoCal HN	Abbott Nutrition
Neocate	Nutricia
Neocate Junior	Nutricia
Elecare	Abbott Nutrition
Nutren 1.5	Nestle Nutrition
Nutren 2.0	Nestle Nutrition
Nutren Jr	Nestle Nutrition
Carnation Instant Breakfast Plus	Nestle Nutrition
Carnation Instant Breakfast Very High Calorie	Nestle Nutrition
Boost Kids Essentials	Nestle Nutrition
Boost Kids Essentials 1.5	Nestle Nutrition
Boost/Boost Plus	Nestle Nutrition
Ultrase	Axcan Scandipharm, Inc
Ultrase MT	Axcan Scandipharm, Inc
Creon	Solvay Pharmaceuticals
Zenpep	Eurand NV
Pancrecarb	Digestive Care, Inc.
Pancrease	Ortho-McNeil Pharmaceutical, Inc
Pancrease MT	Ortho-McNeil Pharmaceutical, Inc
Pancrecarb MS	Digestive Care, Inc.
Viokase tablets	Axcan Scandipharm, Inc
Ursodiol	Teva Pharmaceuticals USA
Actigall	Novartis Pharmaceuticals
Prevacid	TAP Pharmaceuticals Inc
Zantac	GlaxoSmithKline
Prilosec	AstraZeneca Pharmaceuticals, LP
Nexium	AstraZeneca Pharmaceuticals, LP
Protonix	Wyeth Pharmaceuticals
Tobramycin (TOB 1)	
Pulmozyme	Genentech
Azithromycin	
Albuterol	GlaxoSmithKline
Xopenex	Sepracor, Inc
Atrovent	Boehringer-Ingelheim Pharmaceuticals
Spiriva	Boehringer Ingelheim Pharmaceuticals
Brovana	Sepracor, Inc
Pulmicort	AstraZeneca
Pro Air	Teva Speciality Pharmaceuticals
Ventolin	GlaxoSmithKline
Flovent	GlaxoSmithKline
Advair	GlaxoSmithKline
Symbicort	AstraZeneca Canada Inc.
Duocal	Nutricia
Benecalorie	Nestle Nutrition
Scandical	Cardinal Health Pharmaceuticals
Hypertonic Saline	
Lantus	Aventis Pharmaceuticals, Inc
Novolog	Novo Nordisk Pharmaceuticals Inc
Humalog	Eli Lilly and Co
NPH	
Enlive	Eli Lily and Co
Cholecalciferol	

LOW - PROTEIN FOODS

The NBS Benefits Program may cover low protein foods for clients with an identified NBS disorder that prohibit them from eating a regular diet. For purposes of this policy, low protein foods are defined as follows:

- Must be lacking in the compounds which cause complications of the metabolic disorder;
- Are not generally available in grocery stores, health food stores, or pharmacies;
- Are not used by the general population;
- Are not foods covered under the SNAP Food Benefits (aka Food Stamps) program;
- Are products listed in enrolled providers' catalogs

Non-covered food items are snacks and include but are not limited to the following items:

- Candy
- Candy covered items
- Chocolate
- Chocolate covered items
- Cookies
- Cakes
- Pies
- Dessert items
- Chips
- Onion rings
- Cookie dough
- Gum
- Cake mixes

Table B: Diagnosis Codes

2700 Disturbances of amino-acid transport
2701 Phenylketonuria (PKU)
2702 Other disturbances of aromatic amino-acid metabolism
2703 Disturbances of branched-chain amino acid metabolism
2704 Disturbances of sulphur-bearing amino acid metabolism
2706 Disorders of urea cycle metabolism
2707 Other disturbances of straight-chain amino acid metabolism
2708 Other specified disorder of amino acid metabolism
2719 Unspecified disorder of amino acid metabolism

Low-Protein Foods are reimbursable at retail cost.

There is a limit of $200.00 for low-protein foods per client per month.

Low-protein foods will be obtained directly by the client. Contractors will fax the Prescription Request form to the NBS Benefits Program; manufacturer will be provided client's contact information by the NBS Benefits Program. The low-protein food manufacturer will bill NBS Benefits Program directly.

Other dietary supplements will <u>not</u> be reimbursed unless prior approval is obtained from the NBS Benefits Program.

SECTION IV: BILLING AND REPORTING

BILLING AND REPORTING OVERVIEW

Contractors may only bill for the service(s) if:

- The client was screened for potential Medicaid, CHIP, CHIP Perinatal Program, and/or CSHCN Services Program eligibility;
- The client was determined not eligible for Medicaid, CHIP, CHIP Perinatal Program, CSHCN Services Program, or another funding source; and
- The client is determined to be eligible for the NBS Benefits Program.

Reimbursement for physician services are set at Texas Medicaid rates (See Section III of this manual for allowable services). Laboratory services are set at established rates (See Section III for reimbursement rates). Remediation services of dietary supplements are reimbursable at whole sale cost plus 15%. Remediation services of low-protein foods are reimbursable at retail cost. Contractors must submit documentation of purchasing remediation services at the whole sale price. Billing for shipping and handling will be reimbursed for any amount up to $75.00 per order.

- There is a limit of $1500.00 per month per client for dietary supplements.
- There is a limit of $200.00 per month per client for low-protein foods.
- There is a limit of $300.00 per month per client for vitamins.

BILLING REQUIREMENTS

Requests for reimbursement of allowable benefits at established rates are submitted monthly in aggregate on a State of Texas Purchase Voucher. The voucher may be downloaded from: http://www.dshs.state.tx.us/grants/forms/b13form.doc

The Health Insurance Claim Form-1500 document must be accurately filled out for each enrolled client provided services during the payment month and submitted to the NBS Benefits Program with the Purchase Voucher. The Claim Form should be a consolidated list of all services the client received during the month. The 1500 Health Insurance Claim Form may be downloaded from: http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf.

Instructions for completing the State of Texas Purchase Voucher along with an example are found in this section.

Billing vouchers will not be processed for payment unless accompanied by corresponding Health Insurance Claim Forms for service(s) provided to enrolled clients.

Purchase vouchers must be submitted within **30 days** following the end of the month for which services are billed. For example, invoices for the month of February 2009 are due by March 31, 2009; invoices for March 2009 are due by April 30, 2009; invoices for April 2009 are due by May 31, 2009; and so on.

Purchase vouchers must include the payee identification number and the current document number in order to be processed. Payments will be delayed if:

- The voucher does not include the identification numbers listed above, or the numbers are incorrect;
- The mathematical calculations are inaccurate;
- Payment is requested for unauthorized services; or
- More than one Claim Form is submitted for a client with the monthly payment voucher.

NON-REIMBURSABLE EXPENDITURES

Contractors will only bill the NBS Benefits Program for services provided to individuals who meet the eligibility requirements of the NBS Benefits Program. Contractors will **not** request reimbursement for services provided to a client if:

- The individual is eligible for another program;
- The individual did not complete the eligibility process.

Services are often provided to individuals whose screening results indicate they are potentially Medicaid or CHIP eligible, but the client has not yet completed an application (with Medicaid or CHIP) or has not received notification of acceptance or rejection. The NBS Benefits Program may cover services delivered on the initial date of contact if the presumptive eligibility determination is in process. **Once the client's denial letter from Medicaid and/or CHIP is received by the NBS Benefits Program, the contractor may bill for the services provided on the initial day of service as well as subsequent services.**

If the individual is determined eligible to receive Medicaid, CHIP, or another funding source that covers the services, the contractor may not continue to bill the NBS Benefits Program for services provided to the individual. The contractor should retroactively bill the funding source for the individual's initial visit, and credit the reimbursement to DSHS on the next purchase voucher submitted.

BILLING ERRORS

Errors in billing may result in over or under payment for services provided. Errors that result in over billing can be corrected by submitting a revised voucher. For under billing, a supplemental voucher should be submitted along with supporting documentation (i.e., procedure code and new client reports). Clearly mark the words "Revised" or "Supplemental" on the purchase voucher. Explain changes and show calculations on the face of the voucher.

STATE OF TEXAS PURCHASE VOUCHER INSTRUCTIONS
FOR NBS BENEFITS PROGRAM

All sections listed below must be completed in order to receive payment.

SECTION	ENTRY
9. Payee Identification Number	Performing agency's 14 digit code number assigned by the State Comptroller's Office.
13. Document Amount	Amount for which performing agency is billing DSHS for the period indicated in section 19. (Must match reimbursement request in item 23).
14. Payee Name/Address	Performing agency's name, address, city, state, zip. Must coincide with section 9 (payee ID no.) and State Comptroller's Office records.
19. Ser/Del Month	The month and year in which costs were incurred.
20. Description of Goods or Services	Provide description to include: Name of product/service
21. Quantity	For Dietary supplements, and Vitamins - Amount of product in cans, pouches, or bottles
22. Unit Price	For Dietary supplements -Whole sale cost per unit(can, pouch, or bottle)
23. Amount Reimbursement Statement:	Total expenses incurred for the period indicated in section 19 Net reimbursement request (same as document amount in section 13). Reimbursement for services as specified in the contract/manual between the Department of State Health Services and (name of performing agency) For Dietary supplements, List: -Total whole sale cost for product -15% of total whole sale cost -Shipping and Handling and label as Shipping -Total amount of all services listed above* Low Protein Foods, List: -Total retail cost for product -Shipping and Handling and label as Shipping -Total amount of all services listed above
24. Contact Name	Enter name and phone number of person responsible for this account.

Complete all sections listed above and email the voucher within 30 days following the end of the month for which services are being billed to:

*Reminder: Whole sale cost plus the 15% cannot go over $1500 for dietary supplements and $300 for vitamins.

Mail to:
DSHS Claims
PO Box 149347 – MC1940
Austin, Texas 78714-9347

Email to:
Invoices@dshs.state.tx.us

DSHS Form B-13

STATE OF TEXAS
PURCHASE VOUCHER Page ____ of
WP5.1 (9/93)

1. Archive reference number	2. Agency No. **537**	3. Agency Name **TEXAS DEPARTMENT OF STATE HEALTH SERVICES**			4. Current document number
	5. Effective date	6. DOC date 03/31/08	7. Due date	8. Doc Agency **537**	
9.Payee identification number	10. PDT	11. PCC	12. Requisition number		13. Document amount
14. Payee name/address		15. GSC order number		17. AGENCY USE	
		16. Lease number		FUND ___ BUDGET ____ CAT. ____ SERV DATE General_____ or Program_____ Activity Code	

18. SFX 001	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				
18. SFX 002	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				
18. SFX 003	Ref Doc	SFX	M	TC	Index	PCA	AY	COBJ	AOBJ	Amount	R
	APPN	Fund	NACUBO Sub-Fund	Grant number	Grant year/phase	Project number	Project phase	Contract number		Multipurpose code	
	Invoice number			Description			AGENCY USE				

19. SER/DEL DATE	20. DESCRIPTION OF GOODS OR SERVICES	21. QUANTITY	22. UNIT PRICE	23. AMOUNT

24. Contact name	Phone (Area code and number)	25. Entered by

26. I approve this voucher for payment. The above goods or services correspond in every particular with the contract under which they were purchased. The invoice for the goods or services is correct. This payment complies with the General Appropriations Act.

Approved sign here <	Phone (Area code and number)	Date
Fiscal Approved sign here <	Phone (Area code and number)	Date

FORM 1500 HEALTH INSURANCE CLAIM FORM INSTRUCTIONS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

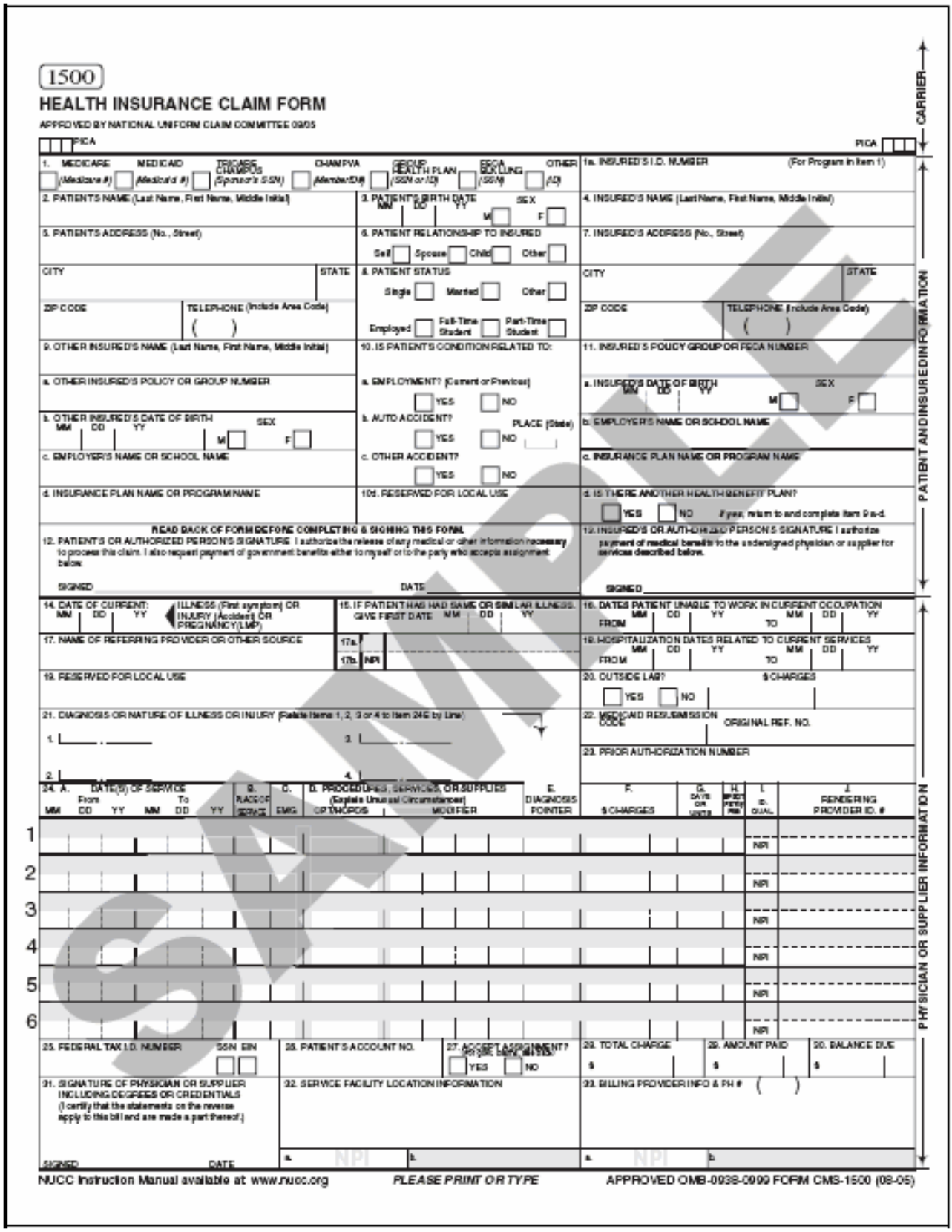
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

FORM 1500 HEALTH INSURANCE CLAIM FORM



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

REPORTING REQUIREMENTS

The **Individual Client Procedures Report** must be submitted to the NBS Benefits Program quarterly by the medical provider.

Instructions for Completing the Client Procedure Report

- ✓ Complete one form per NBS Benefits Program client **seen** during the quarter;
- ✓ At the top of the form, enter the contractor's name, the date on which services were provided, the provider's complete name, the client's complete name, and the client's date of birth;
- ✓ Check appropriate service provided under evaluation and management;
- ✓ For laboratory procedures, list the service description, CPT codes, and Medicaid rate;
- ✓ Enter the client's diagnosis;
- ✓ Enter the time spent with the client and the requested return time period.

The **Productivity Report** must be submitted to the NBS Benefits Program quarterly by the pharmacies and manufactures.

Instructions for Completing the Productivity Report

- ✓ Enter facility/clinic name, physician's name, Person Completing Form and beginning and end date of the reporting quarter
- ✓ Enter total number of prescriptions written for each designated category for the reporting quarter
- ✓ Sign and date
- ✓ Fax, mail or e-mail to DSHS NBS Benefits Program

MAINTENANCE OF RECORDS

Contractors must maintain records that document the necessary information for services provided and billed for reimbursement. Documentation may be audited upon DSHS on-site quality assurance reviews. For guidance on financial administrative requirements, refer to the Financial Procedures Manual for DSHS Contractors, which may be found at http://www.dshs.state.tx.us/contracts/cfpm.shtm.

DEPARTMENT OF STATE HEALTH SERVICES
NBS BENEFITS PROGRAM CLIENT PROCEDURE REPORT

Complete one form for each NBS Benefits Program Client seen during billing quarter

Contractor: _____ Contract #: _____

Date of service: _____ Provider: _____

Patient: _____ Patient DOB: _____

EVALUATION & MANAGEMENT SERVICES (check one)

New patient office visit:
- ☐ 99201 $28.87
- ☐ 99202 $45.56
- ☐ 99203 $61.56
- ☐ 99204 $90.07
- ☐ 99205 $111.98

Established patient office visit:
- ☐ 99211 $14.96
- ☐ 99212 $25.04
- ☐ 99213 $37.64
- ☐ 99214 $52.86
- ☐ 99215 $81.38

New/established office consultation:
- ☐ 99241 $40.47
- ☐ 99242 $70.25
- ☐ 99243 $90.77
- ☐ 99244 $127.28
- ☐ 99245 $169.01

Genetic evaluation and counseling:
- ☐ 99245-TG $370.48
- ☐ 99244-TG $248.68
- ☐ 99214-TG $81.10
- ☐ 99215-TG $147.18
- ☐ 99213-TG $50.76

Specialist Telephone Consultation:
☐ 3-99499 –U9 $28.07

LABORATORY PROCEDURES (write name of test, code & rate; attach list as needed)

Name of test	**Code(s)**	**Rate**

DIAGNOSIS: _____

Duration of Office Visit: **Hrs.** _____ **Min.** _____

Follow-Up: **Wks.** _____ **Months** _____

Mail/fax to:
Department of State Health Services
NBS Open Enrollment
MC 1918, PO Box 149347
Austin, TX 78714-9347
Fax: 512-776-7593

DEPARTMENT OF STATE HEALTH SERVICES

NBS BENEFITS PROGRAM PRODUCTIVITY REPORT

Complete one form for all prescriptions written for NBS Benefits Program Clients during the billing quarter.

Facility Name: _____

Physician's Name: _____

Staff Completing Form: _____

Quarter Dates: _____

Benefits Provided:	**Total Prescriptions:**
▪ Metabolic Formula	_____
▪ Low-Protein Foods	_____
▪ Vitamins	_____
▪ Medication	_____

SIGNATURE (person filling out form**):** _____

DATE: _____

Mail/fax to:

Department of State Health Services
NBS Open Enrollment MC 1918
PO Box 149347
Austin, TX 78714-9347
Fax: 512-776-7593

E-mail to:

benefits@dshs.state.tx.us

CONTRACTOR CLINICAL SERVICES ASSURANCES

Contractors are required to comply with the DSHS Family and Community Health Services Division provisions as follows:

1. To provide benefits in a culturally sensitive and non-discriminating manner;

2. To provide benefits as outlined in the Scope of Work and the NBS Benefits Program Contractor Procedures Manual;

3. To return 100% of revenue collected as co-payments from clients, whose services are reimbursed with NBS Benefits Program funding, to Department of State Health Services, NBS Benefits Program, MC 1918, PO Box 149347, Austin, Texas 78714-9347;

4. To provide DSHS with access to all data gathered by the project, within constraints of client confidentiality;

5. To grant DSHS rights to tangibles, patentable or copyrightable products developed with NBS Benefits Program funding;

6. To comply with all policies and procedures contained in the NBS Benefits Program Contractor Procedures Manual.

SECTION V: OPTIONAL FORMS

STATEMENT OF SELF-EMPLOYMENT INCOME
DECLARACIÓN DE INGRESOS DEL NEGOCIO PROPIO

See Instructions on Page 2./Vea las Instrucciones en la página 2.

Case Record Name	**Case Record Number**

1. **Name of Person Having Self-Employment Income**/Nombre de la persona que tiene ingresos de negocio propio.

_____

2. **Give the number of months covered by this income statement.**
Dé el número de meses que cubre esta declaración de ingresos..... ☐

3. **Describe what you did to earn this money.**/Describa lo que hizo para ganarse este dinero.

_____

_____

4. **List your business expenses and income. IMPORTANTE: Attach receipts, invoices, or other verifying papers.**
Anote los gastos y ingresos de su negocio. IMPORTANTE: Adjunte recibos, facturas, u otros comprobantes.

Date Fecha	**EXPENSES** GASTOS	**Amount** Cantidad
		$

Total Expenses
Total de Gastos $

Date Fecha	**INCOME** INGRESOS	**Amount** Cantidad
		$

→ **SUBTOTAL** $

Enter expenses here and subtract.
Anote el total de gastos y reste. —

NET SELF-EMPLOYMENT INCOME
INGRESOS NETOS DEL NEGOCIO PROPIO $

The above information is true, correct, and complete to the best of my knowledge. I understand that giving false information to the county could result in my being disqualified for fraud./Según mi leal saber y entender, toda esta información es cierta, correcta y completa. Comprendo que si doy información falsa al condado puedo ser descalificado por fraude.

_____ _____ _____

Signature of anyone helping you to prepare this form / Date
Firma de la persona que le ayudó a llenar la forma / Fecha

Signature / Firma

Date / Fecha

If you or any member of your household has any kind of self-employment income, fill out this form and attach it to your application. You may attach a copy of the latest income tax forms in place of this form. If your accounting system is not the same as this form, you may substitute a copy of your accounting statement. You must answer all questions and sign and date at the bottom. **Use additional sheets of paper if you need to.** Sign and date each sheet. Remember, this is your sworn statement. You will need to bring with you to the interview: bills, receipts, checks or stubs, and any other business records you have. Your worker will need to see them. **Your records will be returned to you.**

Self-employment Income. This is any money you earn working for yourself. It is not money you earn working for someone else. If you are in doubt, ask your caseworker.

Questions 1, 2, and 3. These questions are self-explanatory.

Question 4. List your business income and expenses. In the boxes on the left side of the form, list your business **expenses** (see the information below). Write in the dates you paid the expenses and the amount of each expense. Add the amounts, and enter your total in the box "total self-employment expenses." In the boxes on the right side of the form, list your **income** (see the information below). List the dates you received the income, your sources of income, and the amounts. Add the amounts, and enter your total in the box "total self-employment income." Subtract your expenses from your total self-employment income, and enter your "net self-employment income."

Expenses are your costs of doing business. Examples of expenses are supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, payments on principal of loans for income-producing property, capital asset purchases (such as real property, equipment, machinery, and other durable goods and capital asset improvements), your social security contribution for people who worked for you, and labor (not salaries you pay yourself). If you claim labor costs, list each person and the amount you paid them. If you have any other kinds of business expenses, be sure to list them and the date they were paid.

You may not claim:

- Rent, mortgage, taxes, or utilities on your business if it operates out of your home (unless these costs are separate from the costs of your home);
- Cost of goods you buy for the business but use yourself;
- Net business loss from a prior period and
- Depreciation.

If you are in doubt, bring proof of the expense and ask your worker.

Income includes money from sales, cash receipts, crops, commissions, leases, fees, or whatever you do or sell for money. If you have any other kind of income from your business, be sure to list it. Be sure to list the dates income was received.

Who must sign. The form must be signed by the applicant, spouse, or authorized representative. Anyone may help you complete the form, but that person must also sign and date the form. Ask your worker if anyone else needs to sign the form.

Si usted u otra persona de su casa tiene algún tipo de ingresos de negocio propio, llene esta forma y adjúntela a su solicitud. En lugar de esta forma, puede adjuntar una copia de la declaración de impuestos sobre ingresos más reciente. Si el sistema de contabilidad que usa no es igual al de esta forma, puede substituir la forma con una copia de su registro de contabilidad. Tiene que contestar todas las preguntas y firmar y fechar la forma al final. **Use hojas adicionales si las necesita.** Firme y feche cada hoja. Recuerde que ésta es una declaración jurada. Tiene que llevar a la entrevista: cuentas, recibos, cheques o talones de cheques y cualquier otra documentación que tenga del negocio. El trabajador tendrá que verlos. **Estos documentos le serán devueltos.**

Ingresos del Negocio Propio. Este término se refiere al dinero que gana cuando trabaja por su propia cuenta. No es el dinero que recibe cuando trabaja para otra persona. Si tiene alguna duda, consulte con su trabajador de casos.

Preguntas 1, 2, y 3. Estas preguntas no necesitan más explicación.

Pregunta 4. Apunte los ingresos y gastos de su negocio. En las cajas del lado izquierdo de la forma, enumere los **gastos** de su negocio (vea la información abajo). Ponga la fecha en que pagó los gastos y la cantidad de cada gasto. Sume las cantidades y ponga el total en la caja que dice "total de gastos del negocio propio". En las cajas a la derecha de la forma, enumere los **ingresos** (vea la información abajo). Ponga la fecha en que recibió cada ingreso, la fuente del ingreso y la cantidad. Sume las cantidades y ponga el total en la caja que dice "total de ingresos del negocio propio". Reste los gastos del total de ingresos del negocio propio y anote sus "ingresos netos del negocio propio".

Los gastos son los costos de un negocio. Algunos ejemplos de posibles gastos son: provisiones, reparaciones, renta, servicios públicos, semilla, forraje, seguro del negocio, licencias, cuotas, pagos del capital de préstamos para propiedades que generan ingresos, compras de bienes de capital (como bienes raíces, equipo, maquinaria y otros bienes duraderos y mejoras de bienes de capital), su aportación al seguro social de las personas que trabajan para usted y sueldos (pero no los que se paga a sí mismo). Si declara el costo de sueldos, ponga el nombre de cada persona y la cantidad que le pagó a cada quien. Si tiene cualquier otro tipo de gastos del negocio, asegúrese de anotarlos y poner la fecha en que los pagó.

No puede declarar:

- El pago de la renta, la hipoteca, los impuestos o los servicios públicos del negocio si lo opera de su casa (a no ser que estos costos son aparte de los costos de la casa);
- El costo de artículos que compra para el negocio pero que usa personalmente;
- La pérdida neta del negocio de un periodo anterior; and
- La depreciación.

Si tiene alguna duda, lleve comprobantes del gasto y consulte con el trabajador.

Los ingresos son, entre otros, el dinero de ventas, el ingreso de caja, las cosechas, las comisiones, las rentas, las cuotas o cualquier cosa que hace o que vende por dinero. Si usted tiene cualquier otro tipo de ingresos del negocio, asegúrese de anotarlo. No olvide poner las fechas en que recibió el ingreso.

Quién debe firmar. El solicitante, su cónyuge o su representante autorizado para firmar la forma. Cualquier persona puede ayudarle a llenar la forma, pero esa persona también tiene que firmar y poner le fecha en la forma. Consulte con el trabajador para saber si alguien más tiene que firmar.

With a few exceptions, you have the right to request and be informed about the information that the county obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the county to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). To find out about your information and your right to request correction, please contact your local county office. / Con algunas excepciones, usted tiene el derecho de saber qué información obtiene sobre usted el condado de pedir dicha información. Si desea recibir y estudiar la información, tiene el derecho de solicitarla. También tiene el derecho de pedir que el condad corrija cualquier información incorrecta (Código Gubernamental, Secciones 552.021, 552.023, 559.004). Para enterarse sobre la información y el derecho de pedir que la corrijan, favor de ponerse en contacto con la oficina local del condado.

EMPLOYMENT VERIFICATION

Date/Fecha	**Case Record No.**/Núm de Caso
Office Address and Telephone No./Oficina y Teléfono Fax:	

Employee	Social Security Number

This individual is a member of a household applying for health care assistance from the Title V/Primary Health Care Program. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on the back of this letter. If a question does not apply, mark it N/A. After you complete this form, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed by this date: _____. If you could send it before this date, it would be most appreciated.

Thank you for helping. If you have questions, please feel free to call.

I give my permission to release the information requested on this form.
Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.

_____ _____

Signature / **Firma** Date / **Fecha**

Comments: _____

Employment Verification

Employee Name (as shown on your records)
Employee Address – Street, City, State, ZIP (as shown on your records)

Is/was/will this person (be) employed by you?	**Is FICA or FIT withheld?**
☐ Yes ☐ No If yes → ☐ Permanent ☐ Temporary	☐ Yes ☐ No

Rate of Pay	**Average Hours per Pay Period**	**How often is employee paid?**
$ ☐ *Per Hour* ☐ *Per Day* ☐ *Per Week* ☐ *Per Month* ☐ *Per Job*		

On the chart below, list all wages received by this employee during the months of: _____

Date Pay Period Ended	Date Employee Received Paycheck	Actual Hours	Gross Pay	Other Pay * (Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips)

*** In Comments Section below, please explain when and how Other Pay is received.**

Date Hired	**Date First Paycheck Received**	**If employee is/was on Leave Without Pay**
		Start Date: End Date:

If this person is no longer in your employ

Date Final Paycheck Received: Gross Amount of Final Paycheck: $

Is health insurance available?

☐ Yes ☐ No If Yes, employee is → ☐ Not Enrolled ☐ Enrolled for Self Only ☐ Enrolled with Family Members

Comments: _____

Signature and Title of Person Verifying This Information **Date**

Company or Employer	**Address (Street, City, State, ZIP)**	**Telephone Number (Include area code.)**

REQUEST FOR INFORMATION
SOLICITUD DE INFORMACIÓN

Date/Fecha	**Case Record No.**/Núm de Caso
Office Address and Telephone No./Oficina y Teléfono	

Your application for assistance is not complete. To determine your eligibility, we need the following additional information./Su solicitud de asistencia no está completa. Para determinar su elegibilidad, necesitamos la siguiente información.

ONLY THE CHECKED BOXES APPLY TO YOU/SOLAMENTE LAS CASILLAS MARCADAS SE APLICAN A SU CASO.

- ☐ **Mail Addressed to You or Another Household Member**
  Correo Dirigido a Usted o a Otra Persona de su Casa
- ☐ **Texas Driver's License or Other Official Identification**
  Licencia de Manejar de Texas u Otra Identificación Oficial
- ☐ **Voter Registration Card**
  Certificado de Registro Electoral
- ☐ **Notice of TANF, SNAP/ Food Stamps, or Medicaid Benefits**
  Aviso de Beneficios de TANF,Estampillas para Comida o
- ☐ **Paychecks or Paycheck Stubs**
  Cheques de Paga o Talones de Cheques de Paga
- ☐ **Earnings Statement from Employer**
  Verificación de Sueldo Preparada por el Empleador
- ☐ **Worker's Compensation Award Letter or Check**
  Cheque del Seguro Obrero o Carta Diciendo que Van a
- ☐ **Federal Income Tax Return**
  Declaración de los Impuestos Federales Sobre los Ingresos
- ☐ **Self-Employment Bookkeeping, Sales, Expenditure Records**
  Comprobantes de Cuentas, Ventas, Gastos de Trabajo Independiente
- ☐ **Social Security Award Letter, Check, or Denial Notice**
  Cheque de Seguro Socil o Carta Diciendo si se lo Van a Dar o No
- ☐ **Disability Insurance Award Letter or Check**
  Cheque de Seguro por Incapacidad or Carta Diciendo que Van a Dárselo
- ☐ **Unemployment Compensation Award Letter or Check**
  Cheque de Compensación de Desempleo o Carta Diciendo que Van a Dárselo
- ☐ **Veterans Administration Award Letter or Check**
  Cheque de la Administración de Veteranos o Carta Diciendo que Van a
- ☐ **Other Items**
  Otra

_____

_____

_____

_____

PLEASE RETURN THE ITEMS CHECKED ABOVE BY:
HAGA EL FAVOR DE ENVIAR LOS DOCUMENTOS ENUMERADOS PARA EL:

If we do not receive the information we need and you do not contact me, I will assume that you do not want assistance. Call me if you have any questions./ Si no recibimos la información que necesitamos y usted no se comunica conmigo, supondré que usted no quiere asistencia. Si tiene alguna pregunta, háble me.

Signature/Firma: _____

APPENDIX: State Resources

RESOURCE	WEB SITE AND CONTENTS	PHONE NUMBER
Children with Special Health Care Needs Services Program DSHS administered program that provides services to children under 21 who have extraordinary medical needs, disabilities, and chronic health conditions.	http://www.dshs.state.tx.us/cshcn/ • Program description • Health benefits • Case management services • Family support services • Client application and forms • Provider manual and application	1-800-252-8023
Client Services Contracting Unit (CSCU) website DSHS web site for frequently asked contracting questions and a list of contact numbers for specific questions.	http://www.dshs.state.tx.us/grants/ • Contracting questions and answers • State of Texas Purchase Voucher • Form #GC-10 (270) • Financial Administrative Procedures Manual • General provisions • Laws and regulations • Funding links	
County Indigent Health Care Program (CIHCP) Program that provides health services to eligible residents through counties, hospital districts, and public hospitals in Texas.	http://www.dshs.state.tx.us/cihcp/ • Program description • Income and eligibility criteria • Available services	1-512-776-7706
Literature and Forms Inquiry & Order Entry System	http://webds.dshs.state.tx.us/mamd/litcat/ • Instructions for ordering/downloading DSHS publications	
Genetic Services DSHS information and referral program. Oversees Title V genetic services programs across the state.	http://www.dshs.state.tx.us/genetics/ • Provider list by health service region • Interagency Council for Genetic Services • Genetics information and literature	1-512-776-7111 ext. 6675
Newborn Screening (NBS) Texas newborns are required to be screened for certain disorders during the birth admission. DSHS maintains a NBS laboratory and provides case management services.	http://www.dshs.state.tx.us/newborn/ • Screened disorders • Expansion information • Practitioner's guide • Specimen collection procedures • Available literature	1-800-252-8023 ext. 2129
Primary Health Care Program DSHS administered program providing primary health care services to persons at or below 150% FPL who do not qualify for other health programs.	http://www.dshs.state.tx.us/phc/ • Program description • Income and eligibility criteria • Services provided • Provider list by health service region	1-512-776-7796
Quality Monitoring Branch, Performance Management Unit Responsible for assuring that contractors funded by DSHS meet standards and requirements of the department.	http://www.dshs.state.tx.us/qmb/ • Policies, procedures, tools and instructions for on-site monitoring reviews • DSHS Standards for Public Health Clinic Services	1-888-963-7111 ext. 6250
CHIP/Children's Medicaid Texas families with uninsured children may be able to get health insurance through Children's Medicaid and the Children's Health Insurance Program (CHIP).	http://www.chipmedicaid.org/english/index.htm • Program descriptions • Income and eligibility criteria • Client application • Consumer guide to better health	1-877-543-7669
Title V Maternal & Child Health Fee-for- Service Provides prenatal care, preventive and primary child care, case management for children from birth to one year and high risk pregnant women, as well as dental care for children and adolescents.	http://www.dshs.state.tx.us/mch/fee/default.shtm • Program description • Income and eligibility criteria • Services provided • Provider list by health service region	1-512-776-7796
Women, Infants and Children Program (WIC) Federal supplemental nutrition program administered by DSHS in Texas.	http://www.dshs.state.tx.us/wichd/ • Program description • Eligibility criteria • How to become a WIC client	1-800-942-3678